

Care and Support in the Community for Older People in New Zealand

Issues paper
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SECTION 1 – INTRODUCTION

This issues paper is designed to share learning about care and support in the community for older people in New Zealand and provide a focus for discussions with key stakeholders about the future direction and possible options for community and home-based care services for older people.

The issues paper summarises:

- What we have learned from international research and trends and New Zealand research and experience;
- What have emerged as the key elements of successful community-based services and programmes for older people;
- The challenges of providing services in the community.

Feedback from stakeholder discussions and comments on this issues paper will help shape policy, funding and service delivery for effective community care and support for older people into the future. Refer to section 6 for questions and the feedback process.

The Positive Ageing Strategy

The 2001 New Zealand Positive Ageing Strategy provides a framework for integrating policies and programmes across the whole government sector at national, regional and local level. Each year since 2001 progress against annual action plans to achieve the 10 positive ageing goals are reported on to Government at the end of each financial year. (Refer The New Zealand Positive Ageing Strategy annual report 2005/06 and action plan 2006/07).

A key health action from the Positive Ageing Strategy was development of the Health of Older People Strategy (2002), which sets out the government's future policy direction for health and disability support services for older people.

The vision of the Health of Older People Strategy is that older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life; older people are supported in this by coordinated and responsive health and disability support programmes. The Strategy identifies eight objectives as key areas where action is needed to achieve its vision. (Refer to www.moh.govt.nz/olderpeople for an electronic copy).

Implementing the Health of Older People Strategy by 2010 requires the Ministry and DHBs to systematically review and refocus services and policy to better meet the needs of older people now and in the future. One of the primary aims of the Strategy is to develop an integrated approach to health and disability support services for older people that recognises their preferences for where they live and is responsive to their varied and changing health and disability support needs. This approach is referred to as the "integrated continuum of care".

The preference to live at home

The relationship between people and their environments has been identified as a central element of the ageing process (Binstock, 2000). There is international evidence that most (but not all) older people prefer to receive care at, or as close to, home as possible (Wanless, 2006). This is supported by qualitative research in New Zealand (e.g. Barrett *et al* (2005) and Parsons *et al* (2006)). Demand for, and provision of, home care is increasing worldwide (Hutten and Kerkstra, 1996).

However, some researchers have identified that moving care into the home and community can have significant consequences. The experience is often complex for the older people who are the focus of care and for the informal and formal providers of care (Wiles, 2005). For example, there can be a blurring of public and private space within the homes of people providing care, which Milligan refers to as "an institutionalisation of ...private space" (Milligan, 2004). Home care can also be related to social isolation as the nature and use of the home changes (Wiles, 2005).

The percentage of all people aged 65 and over in residential care at any point in time is between 5% and 7%, however, it is estimated that 25% to 30% of people who reach the age of 65 can expect to spend some time in long-term care before they die (Ministry of Health, 2002).

Older people enter long term residential care for a variety of reasons. Factors identified by researchers (including MacLennan *et al* (1984), Stilwell and Kerslake (2004), Wang *et al* (2001), Weatherall *et al* (2004)) include:

- the reduced ability to maintain activities of daily living (ADLs)¹;
- continence problems cognitive impairment e.g. dementia;
- loneliness;
- the absence of a carer available full or near full time;
- mobility problems;
- a range of non-health issues such as age at time of entry, marital status, children, death of spouse, ownership (or not) of residence and financial resources.

Additionally, the New Zealand based ASPIRE study (Parsons *et al*, 2006) found that the failure to halt or reverse functional decline; social isolation; a critical event e.g. a fall or hospital admission; negative mood; inadequate meals and/or insufficient hydration; delirium; and high carer stress were also factors correlated with the increased likelihood of entering residential care.

This research and other work indicates that many people who enter residential care could have remained in the community if they had received a sufficient level of community support. A recent Australian study (Stilwell and Kerslake, 2004) found that two-thirds of the study participants who had entered care could have remained in their own home with additional support.

¹ The term "activities of daily living," or ADLs, refers to the basic tasks of everyday life, such as eating, bathing, dressing and toileting.

Demographic Pressures

New Zealand has an ageing population. The number of older people will increase significantly as a proportion of the population over the next 50 years.

The likelihood of having a disability increases with age, and consequently older people are more likely to need additional support services to remain living at home, or may need to move into residential care. The Statistics New Zealand 2001 Household Disability Survey and Disability Survey of Residential Facilities showed that while 74% of people aged 65 to 74 years were able to live at home without assistance, this dropped to 15% of those 85 and over. The number of older people who required assistance to live at home rose from 24% in the 65 to 74 year old age group to 57% in the 85 and over age group.

Currently between 5% and 7% of the population aged over 65 years are in residential care, with most in rest home level beds. Over time, increasing the range and number of effective community-based care services can decrease the demand for residential care. However, where people can be successfully supported to live in their own homes, they are likely to be older and have higher levels of need if and when they enter residential care.

Of particular relevance are the predicted increases in the number of older Māori and older Pacific people (especially those aged 75 and over). The need for culturally appropriate health and disability and social care resources for Māori and Pacific peoples will be considerable, given that people aged 75 and over in general utilise three times the amount of health care resources of other age groups, and also given that Māori and Pacific people have a higher incidence of what are commonly thought of as age-related conditions at younger ages.

As the population ages there will be increasing cost pressures. Expenditure on older people (12 percent of the population who were aged 65 and over) in 2002 was about 39 percent of total Vote Health spending. By 2021 it is projected that 17.6 percent of the population will be aged 65 and over and, based on current expenditure, will consume about 49.6 percent of total Vote Health service expenditure.

As the number of people requiring care and support in the community increases dramatically over the next decade, it will be important to develop cost-effective services along the continuum of care that provide the greatest amount of care, support and well being for older people, within the limits of affordability.

SECTION 2 – THE INTEGRATED CONTINUUM OF CARE

The integrated continuum of care covers the whole range of services provided for older people, from health promotion and primary care to rehabilitative and restorative approaches.

Wanless (2006) summarises an integrated continuum of care in the following diagram.



Low-level services usually include home based support services such as household management and personal care. There is some international evidence that low-level services provided to older people with lower levels of need – usually provided in the community – can delay entry into hospital or residential care. If people are moved too quickly to the intensive end of the spectrum, cost-effectiveness is an issue. If people remain at the low intensity end for too long, safety and risk become issues (Wanless, 2006).

Community-based services are usually provided within older people's homes or within their local community. Key features of community care include the development of needs-driven packages of services provided in the locality of residence of the older person (Litwin and Lightman, 1996) that may involve formal or informal care and support.

Traditionally, home based support services have consisted of a combination of household management and personal care. As an alternative to acute hospital care, home care can include:

- planned early discharge with home support;
- rehabilitation at home (with or without planned early discharge);
- specialist nursing outreach services at home;
- specialist geriatric services delivered at home;
- "hospital at home" – hospital level 24 hour nursing and specialist medical input at home, either after hospital discharge or to avert hospital admission;
- specific 'high tech' techniques and equipment used at home e.g. intravenous therapies, renal dialysis;
- quick response teams and primary care based preventive interventions to avoid or reduce acute hospital admission (Wainwright, 2003).

Intermediate care includes early treatment and rehabilitation to prevent disease or disability, and slow-stream rehabilitation or convalescent care following discharge from hospital. Services can be delivered in hospital, day hospital or at home; and can cover high intensity to low-level services (Godfrey *et al*, 2005).

In practice, the various types of services under community based care and intermediate care may overlap.

Long-term care refers to either community or residentially based care and support provided by voluntary caregivers and/or professionals to older people who are not fully capable of self-care.

Eligibility for services are based on an older person's assessed level of need. Needs assessments are usually carried out by multidisciplinary teams based in hospitals or Needs Assessment/Service Coordination (NASC) teams. Referrals come from a variety of sources, including GPs, allied health professionals, ACC, specialist agencies, families/whānau and sometimes older people themselves.

The other key role of NASCs is service coordination, which is the process of identifying, planning and reviewing the package of services required to meet the prioritised needs and goals of the older person and, where appropriate, for their family, whānau and carers.

Care and support services in New Zealand are provided by organisations in the public and private sectors, including local and national government agencies, religious and welfare organisations and, increasingly, commercial businesses.

While statutory and independent organisations have a role to play, it is well recognised that most care is provided by family, friends and neighbours (Milligan, 2004).

It's broader than health and disability

This issues paper focuses on the role of health and disability support services in enabling older people to continue living in the community. There is a strong focus on the services funded by district health boards and the Ministry of Health.

Research by the New Zealand Institute for Research on Ageing (NZIRA,2005) indicated the complex and often cross-sectoral factors that impact on an older person's ability to "age in place", including:

- access to a variety of housing options that take account of changing needs, changing support needs and income levels;
- the ability to participate in the social domain highlighting the need for access to transport e.g. use of taxi vouchers;
- maintaining strong social and support networks, raising issues such as availability and accessibility of family and friends; the preparedness of older people to ask for help; the management of bereavement and loss; the importance of maintaining good mental health; the possibilities of intergenerational friendships; and the role of Church networks particularly for older Pacific people;

- sufficient income to promote choice;
- access to appropriate and individualised health and home-based services that are responsive to different degrees of fragility and different needs for intensity of service and provide appropriate levels of support to caregivers;
- the need for agency coordination.

Positive Ageing is more than just about health and disability. The Positive Ageing Strategy relies on input from a wide range of government agencies at national, regional and local levels to provide services to care for and support older people in the community.

As well as the Ministry of Health and DHBs, contributing local and central government agencies include:

- city councils;
- district councils;
- Ministry of Social Development (including Office for Disability Issues, Office for Senior Citizens, Older People's Policy, and Work and Income);
- Accident Compensation Corporation;
- Department of Building and Housing;
- Housing New Zealand Corporation;
- New Zealand Fire Service Commission;
- Department of Labour;
- Land Transport New Zealand;
- the Ministry of Pacific Island Affairs;
- Te Puni Kokiri.

Any plans for future development of community-based care for older people funded through the health and disability sector need to take account of these other players when designing service programmes or changes.

SECTION 3 – RESEARCH ON CARE AND SUPPORT IN THE COMMUNITY FOR OLDER PEOPLE IN NEW ZEALAND

Research about services that provide care and support in the community for older people in New Zealand has been limited.

ASPIRE

A recent study – The Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) – evaluated three existing ageing in place programmes for older people with high and complex support needs to promote their independence and their continued ability to live in the community. The three programmes evaluated were:

- The Coordination of Services for Elderly (COSE) programme in Christchurch; an individual case-management model of care;
- The Promoting Independence Programme (PIP) in Lower Hutt; a rehabilitation service model of care; and
- The Community Flexible Integrated Restorative Support Team (Community FIRST) programme in Hamilton; a restorative home support model of care.

The research aimed to determine the effectiveness of each intervention compared to conventional health care services (usual care²) in each region. This included measuring:

- the effectiveness in preventing or delaying the time before a community-based older person requires permanent residential care;
- the effectiveness in improving survival;
- the impact on older people's independence and health-related quality of life;
- the impact on the quality of life of carers;
- the costs and effectiveness of each intervention (compared to usual care) on the dimensions of extending life and delaying entry into residential care.

The study design was based around three randomised control trials with a total sample size for analysis of 569 older people assessed as having high or very high (complex) need, across the three centres. Christchurch had the largest sample size with 351 participants compared with 113 in Hamilton and 105 in Lower Hutt.

Key results

The ASPIRE study found all three programmes reduced the risk of mortality and entry into residential care compared to usual care; and that carer stress levels did not appear to rise in the intervention groups, however the sample size for two of the interventions was not sufficient to yield statistically significant results. In summary:

² Usual care is not defined in the ASPIRE final report, but in context refers to the usual packages of care and support put together by a NASC agency for older people with high or complex support needs

- All three services reduced the risk of mortality compared with usual services in their respective regions, although the small sample size impacted on the statistical significance of the findings. Mortality risk was reduced by 28% for those enrolled in Community FIRST, 14% in PIP and 10% in COSE;
- All three services reduced the risk of entry to residential care in comparison with usual care. The COSE programme reduced the risk by 43%, Community FIRST by 33% and PIP by 16%. The lower sample size for Community FIRST and PIP impacted on the statistical significance of the findings for these interventions;
- Carer stress levels did not appear to rise in the intervention groups in comparison to usual care, despite older people with high and complex needs continuing to live at home;
- An improvement in the independence levels of older people (as measured by Activities of Daily Living) in the Community FIRST initiative was noted, in comparison to usual care. No change was noted in function in the COSE or PIP initiatives in comparison to usual care;
- An incidental finding of the research was that the current Support Needs Level Assessment process used by NASCs to determine need, and thus the allocation of services, was highly variable across the three District Health Boards. Older people in Christchurch were assessed as requiring residential care with a lower level of disability than those living in Hamilton and Lower Hutt. The MDS-HC (InterRAI) assessment tool used by the research team appeared to provide a more rigorous and standardised method of assessment. The variation in needs assessment explains some of the variation between the outcomes achieved for the different services in the three regions;
- Predictive modelling of the likelihood of older people being hospitalised or entering residential care was also undertaken using the complete data set. The results of this modelling show that:
 - If a functional decline occurs in older people, the older person is 11 times more likely to enter residential care;
 - An older person is almost twice as likely to enter residential care if they are socially isolated;
 - If an older person reports having a negative mood, they are over twice as likely to be admitted to residential care;
 - For every one unit increase on the Caregiver Reaction Assessment (which measures caregiver stress), there is a 7% increased risk of residential care entry;
 - When an older person has inadequate meals or experiences dehydration, they are over twice and 1.7 times more likely to be admitted to residential care, respectively;
 - Older people with delirium are 3.6 times more likely to enter residential care;
 - A lack of medication review (almost twice as likely), negative mood (1.5 times more likely) and previous hospitalisation (1.8 times more likely) are all correlated with increased risk of hospitalisation.

Older People Entering Residential Accommodation (OPERA)

The Older People Entering Residential Accommodation (OPERA) research was undertaken as part of a PhD thesis, and was based on in-depth interviews with a sub-sample (131 people) of the ASPIRE study population. OPERA used qualitative research methods to determine the influences that surround entry to residential care, and older people's satisfaction with the decisions regarding their permanent residence.

The OPERA study found that:

- having the ability to make their own decisions and to be able to cope at home are very important to older people, as is their place of residence.
- while many older people felt they had made the decision to enter residential care themselves, in most cases the family and NASC services thought that the family had been the main decision makers.
- nearly half of those who had entered residential care were 'sad' or 'very sad' about the decision. In contrast, three-quarters of those living in their own homes were 'happy' or 'very happy' with their place of residence.

Findings from the economic evaluation

The economic evaluation compared the incremental costs and benefits of the three interventions against usual care services provided in the same region. The analysis found that all three interventions increased the time spent in the community over a 12 month period by decreasing the time spent in residential care and increasing the length of life.

The costs referred to in the findings below were measured in terms of the health care resources used by the study's participants, and included the community costs incurred by the DHB and the older person, and the residential costs associated with permanent entry into either a rest home or hospital.

- The Community FIRST initiative cost an additional \$13,843, per person over a 12 month period compared to usual care (estimated cost \$32,413), and resulted in an additional 51 days spent in the community (of which 16 were avoided residential care and 35 were avoided death). This amounts to a cost of \$271 per person for each additional day in the community over a 12 month period;
- The PIP initiative cost an additional \$7,828 per person over a 12 month period compared to usual care (estimated cost \$32,732), and resulted in an additional 23 days spent in the community (of which 22 were avoided residential care and 1 was avoided death). This amounts to a cost of \$340 per person for each additional day in the community over a 12 month period; and
- The COSE initiative cost an additional \$157 per person over a 12 month period compared to usual care (estimated cost \$13,779), and resulted in an additional 8

days spent in the community (of which 7 were avoided residential care and 1 was avoided death). This amounts to a cost of \$20 per person for each additional day in the community over a 12 month period.

Ministry of Health comment on ASPIRE

The evaluation of three initiatives that promote care and support in the community is an important piece of research in that it evaluates programmes that are 'up and running' in the New Zealand context. The study, which has focussed on older people with high and complex needs, also provides a platform for continued discussion and debate about the types of services that can be provided for older people along the continuum of care, and about the cost and effectiveness of those services relative to alternatives.

The Ministry notes that the sample sizes for the PIP and Community FIRST programmes were smaller than planned, mainly due to difficulties recruiting participants into the study. The overall results however, are indicative of the likely outcomes associated with community-based programmes and are consistent with the findings from international research on the effectiveness of similar interventions.

Sensitivity analysis was required to allow for uncertainty surrounding unit cost, resource use, outcomes variables, time period, and assumptions used to calculate the incremental costs. The sensitivity analysis carried out for ASPIRE showed that the results can be quite sensitive to changes in the average resource use and to the cost assumptions used. The Ministry is undertaking further statistical analysis with a range of cost assumptions to ascertain how changing these impact on the cost-effectiveness ratios.

The sample for Community FIRST had much higher levels of mean physical and cognitive disability at entry into the ASPIRE trials than the sample for COSE, with PIP having a mean level of disability between the two other programmes. These differences, which were not adjusted for in the economic evaluation, may mean that although Community FIRST appears more expensive for the outcomes it achieves, but this may be because it faced greater challenges with its sample participants.

The economic evaluation does not provide DHBs with the financial information required to initiate or fund community-based programmes. This is not the purpose of economic evaluation. The economic evaluation provides an assessment of the relative costs and benefits of different programmes seeking to achieve similar outcomes. The economic evaluation does not provide a measure of benefit across all types of services that the health system provides for older people e.g. hip replacements. The economic evaluation does make explicit, however, the benefits gained from allocating resources to the initiatives described. This analysis allows, and indeed prompts, informed debate about the relative merits of investment in these types of initiatives compared to alternatives.

In particular, many community-based programmes provide high-level care and support for people with high and complex needs. The benefits, in terms of maintaining independence and well being and delaying entry into residential care, of providing lower level care and support for people with lower levels of needs, has not been fully explored in New Zealand. There is international evidence, noted in section 2 (Wanless 2006), that low level community services at relatively lower cost provided

to people with a lower level of need can also delay entry into hospital or residential care.

The COSE initiative – the Christchurch case management model evaluated as part of ASPIRE – demonstrates that it is not only *what* services we provide but how we *co-ordinate* them that can make a difference to outcomes for older people.

An important finding from the study was the variability in assessment of need, and hence the provision of services for comparable people, across District Health Boards. There is considerable scope for standardisation of assessment. This would increase national consistency but more importantly ensure that people receive more appropriate and more cost-effective services, according to need.

The Ministry notes that the evaluation of the InterRAI MDS-HC assessment tool is almost complete. The evaluation findings will provide guidance for decisions on a suitable tool to achieve greater consistency and reliability in assessing the health status and care needs of older people.

When DHBs picked up all existing contracts on devolution in 2003, they inherited whatever mix of services, gaps or over-capacity in services that their regions were experiencing at the time of devolution. The Ministry is aware from other work that there is large variation in the use of rest home beds between DHBs, with the number of contracted rest home beds ranging between 2% and 7% of the total number of people in DHB populations aged over 65. The regional variation may indicate that some DHBs might have an over supply of rest home beds; that some have high utilisation rates per head of population or that some DHBs might be using rest home care where home based support services are more appropriate. This indicates there is still scope to shift resources in some regions towards community-based services. In the future, rest homes are more likely to have a greater focus on rehabilitation, respite care and palliative care. This could result in a reduction in the number of beds required by long stay residents.

The Ministry welcomes discussion and debate about ASPIRE, and the implications of the ASPIRE findings, for the development of future services for the care and support of older people in the community.

Both the final ASPIRE research report and the economic evaluation report are available on the internet at www.moh.govt.nz/olderpeople.

SECTION 4 – COMMUNITY-BASED INITIATIVES

ASPIRE was an evaluation of three initiatives, however a wide range of community-based health and disability programmes have been implemented or are being piloted by DHBs, ACC and service providers around New Zealand. A recent stocktake survey by DHBNZ of DHB implementation of the Health of Older People Strategy highlighted the DHB activities and programmes that have been, or are being, undertaken. Below are some DHB examples of planned changes to older people's services resulting from reviews, and some DHB examples of initiatives that provide care and support in the community.

Capital and Coast DHB

Capital and Coast DHB (CCDHB) is developing an approach for its population for all services to work together so that consumers perceive that they receive a seamless continuum of care. The principles for service delivery guiding development include: active decision making by the consumer and family/whānau, based on sound information; a wellness approach that seeks to assist people to be able to do the things they want; a strengths based approach; a restorative focus seeking to assist people to regain, maintain and improve function; flexibility; a wide range of available options; strengthening the involvement of the consumer in the community and support for family/whānau and other informal carers.

To achieve this, CCDHB is undertaking a comprehensive programme to change the way home, community, primary and specialist services are integrated. This involves combining funding streams, and developing new services that will provide a single point of entry with centralized care planning and coordination, comprehensive assessment, care management for high needs people and flexible, responsive packages of home and community care. It also includes improving support for informal carers, taking a proactive, preventative approach involving early access & assessment of carers' needs, flexible services from a wider menu and ongoing review.

CCDHB is using the InterRAI suite of assessment tools to collect standardised information, which allows information to be shared across health and support providers. This reduces the number of assessments any one person has to have and improves the coordination of care across services. It also provides the DHB with the information it needs to begin to take a population health approach to service provision.

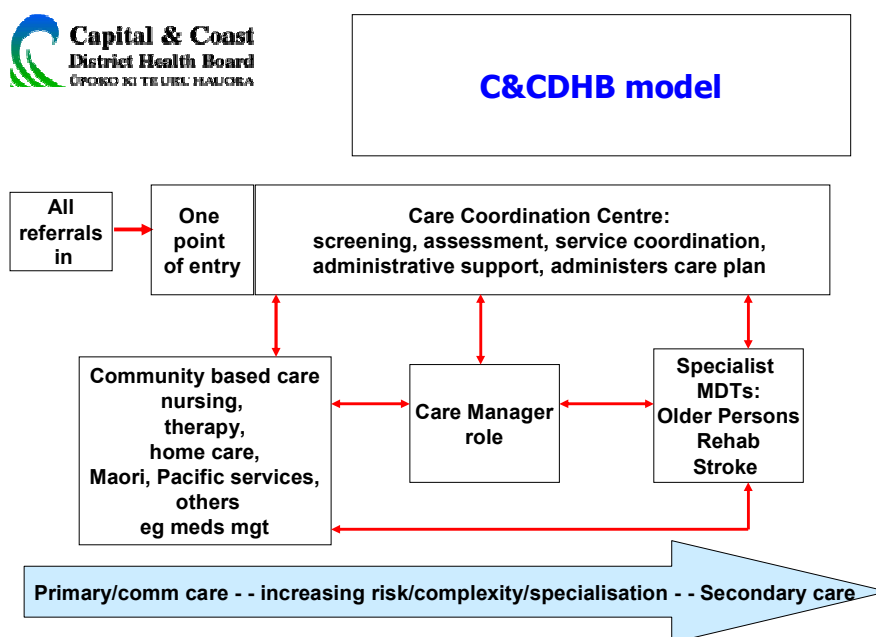
CCDHB's restorative home and community packages of care aim to support people to regain and/or maintain and increase their ability to control their own lives and their functional ability. The term "restorative" applies simply to this concept - where all interventions start from the default position that the aim is to assist the person to be in control and to regain, maintain and increase function. If the evidence is that the person will not regain function, that they have a permanent disability or that they are dying and therefore need palliative care, then the assistance may change, although the goal of ensuring the person feels in control will remain.

The packages are generated by a process of initial assessment and goal setting, review and re-assessment within a package as required. Services being coordinated

can include: community nursing, allied health, community support, complex personal care and telephone monitoring. It can also include wider services available within the community such as ACC-funded falls prevention and recovery services or NGO support. There is also increasing coordination across the primary healthcare and secondary services interface.

The restorative home support component within the packages is delivered based on a support plan developed from an InterRAI assessment and the consumer's goals. It is delivered by trained support workers who are supervised by registered health professionals as part of an appropriate multidisciplinary team. The registered health professional also maintains oversight of the consumer and regularly reviews the support plan. The approach is flexible, responding to changes the consumer makes as they regain function.

The key elements of the Capital & Coast integrated care programme are; a systems approach throughout, workforce development, sound information for all involved, maintaining a consumer point of view, and a developmental, collaborative approach to working with providers.



Thursday, 21 December 2006

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Hawkes Bay DHB

Hawkes Bay DHB has entered into collaborative arrangements with various providers to supply community-based services. For example:

Alzheimers Society

This service focuses specifically on supporting clients and their families who may have been diagnosed with early dementia. The service aims to put early supports in place to ensure the client and family can continue to live independently at home.

Dementia can have a huge impact on the lives of clients and family, so this service will aim to minimise the negative impacts associated with the condition.

Kainga Tautoko - Te Taiwhenua o Heretaunga

Kainga Tautoko will provide a cost effective, client driven, flexible, integrated community based support service for kaumatua which will enable them to age in place. The service will be targeted at all kaumatua within Hawke's Bay, and will employ 1 FTE (registered nurse) to support them. Each kaumatua will have a care plan that focuses on the individual goals of the client. Kainga Tautoko will also link into the fortnightly kaumatua hui held by TTOH.

Enliven - Presbyterian Support East Coast

Presbyterian Support East Coast is establishing community based support services for older people in the Hawkes Bay. The service will be targeted at those older people whose needs indicate eligibility for residential care but who choose to remain in their own home.

The personal care component of the residential care subsidy will be used to provide a flexible package of services in the community, tailored to the needs of each client. The funding model is one of a bulk allocation per client per week and flexibility as to how this money is used. This differentiates it from traditional Home Support packages.

Nelson Marlborough DHB

Nelson Marlborough DHB (NMDHB) has conducted a review of home based support services (HBSS) that are funded by the DHB for older people who are not able to be fully independent. The existing model of care for older people was not considered to be delivering against expected outcomes, and was not considered to be sustainable into the future. The review covered community-based support services for older people; the interface of such services with residential care and other support services; and looked at the relationship with other services for older people, e.g. primary care, specialist medical services.

The review focused on finding ways of generating home-based services that are:

- sustainable, and able to attract and retain a skilled and experienced workforce;
- rehabilitation focused, with strong links to allied health, district nursing & specialist geriatric services, as well as well trained and supervised staff;
- based on good assessment, so that people get the services they need;
- tailored flexibly to the person – to make best use of resources and to allow innovation;
- developed in conjunction with hospital and residential services;
- adequately resourced, with well-managed budgets and with clear, equitable criteria for access to services.

The findings indicated the need for a new model of care. A change from 'fee for service' funding to a packages-of-care approach is recommended. There will be

standard, high and complex, transitional and household management packages of care, with capacity to be flexible and vary as determined by individual need, with a restoration/rehabilitation focus.

The dimensions of service provision will include:

- An assessment process focused on identifying opportunities for the person to regain and maintain fitness and independence, which utilises approaches and tools recognised as supporting current best practice, goal and rehabilitation-focused (it is proposed the current NASC arrangements will be retained);
- Goal identification focused on regaining/maintaining independence, with outcome measures in place;
- a Support Plan able to include a broad range of support and services, which will be delivered by skilled workers, trained to respond to a range of needs;
- a key worker responsible for managing the ongoing co-ordination of the person's support services;
- the HBSS provider may well not be able to directly provide all the services in a package themselves, but could subcontract with other agencies to do so, and will refer to responsive allied health and district nursing services accessed through DHB contracts.

Where possible, processes that are currently effective would remain unchanged. More information about NMDHB's review is included in the next sub-section about DHB programme evaluations (refer page 20).

Wairarapa DHB

Support to Live at Home (SLH)

The Support to Live at Home (SLH) programme run by Wairarapa DHB is for older people who wish to live in their own home, and:

- have needs that are not met by services currently available;
- require additional support because of increased needs;
- could benefit from a case management approach;
- are in a residential care facility and require a transition to home.

The SLH programme was developed as a response to various local issues in the Wairarapa, including:

- the local NASC agency had identified that most older people were entering long term residential care because of social situation rather than increasing physical needs;
- the service provision and notification system through HealthPAC is not flexible enough to adequately meet the fluctuating time needed for some older people's care;

- Wairarapa has a shortage of residential care beds - traditionally very high occupancy rates, and relatively low access rates to residential care. An Expression of Interest process for increased beds was undertaken in June 2006.

Key aspects of the SLH programme are that:

- the level of support is determined through the NASC process, or Personal Health Coordinating Process (the criteria for determining access to components within SLH are equitable with the DHB's access criteria for home based support services);
- the focus is on the total assessed need of the older person (including their social situation);
- funding parameters are agreed up front with the provider (according to the support package allocation (SPA) tool);
- providers submit a costed support plan which has been developed with the older person and their family, whānau or carers;
- the service plan may incorporate a number of support service components (e.g. home help, personal care, respite care, meals on wheels, enabling connection with the community);
- a key worker is designated to manage the service for the person and link to other relevant health/disability services.

The advantages are that it:

- enables social needs to be met;
- is more flexible than purchasing single units of support;
- is a holistic approach, which aligns well with the preferred models of care for Māori;
- is based on goal setting by the older person.

The main challenges for achieving success include:

- a shift is required to focus on outcomes rather than on inputs (which is the focus of current contracting)
- it is difficult to contract for such a service within the current national service framework, through the HealthPAC payment system. To simplify invoicing and reporting to HealthPAC, the provider invoices for the agreed total amount, but reports day-to-day variations in usage of service components to the NASC agency;
- it depends on effective relationships between the DHB, the NASC agency and provider.
- provider capacity and capability – the lead provider is predominantly a rest home/hospital facility but has capacity and expertise in the community;
- SLH clients have to be managed across a large geographical area, which requires coordination and cooperation with other providers and local communities.

DHB PROGRAMME EVALUATIONS

Some DHBs have already undertaken, or are about to undertake, evaluations of the effectiveness of their ageing in place programmes established in their regions. For example:

Nelson Marlborough DHB

An external evaluator has been contracted to identify the success factors of the new model of care programme, which will include an economic evaluation and the client impact (e.g. achieving personal goals; community participation; perception of their ability to cope at home). The evaluation will take place over a year (2007) and the primary focus will be on the client's response to the programme.

Nelson Marlborough DHB has also recently reviewed the home based support services funded by the DHB for older people who are not able to be fully independent.

It was recognised that current contracting methods and philosophies were not delivering against expected outcomes for older people or the professionals who were involved in service delivery. The cost of delivery of HBSS is around \$5.7 million a year and expenditure on these services has been increasing each year. Continued investment in the current model of care is not sustainable into the future.

The review methodology included full consultation and involvement of the wide range of stakeholders; a comprehensive assessment of national and international models of care; and a joint costing project between local providers and NMDHB Planning and Funding, to inform current and future price offers. The review findings indicated the need for a new model of care.

The review covered community based support services for older people and the interface of these services with residential care and other support services. The review also looked at the relationship with other services for older people, such as primary practice and specialist medical services.

Developing home based services was recognised as being crucial for making the best use of hospital and residential care resources.

The review recommended a change in models of care, from 'fee for service' funding to a packages-of-care approach. There will be standard, high and complex, transitional and household management packages of care.

The packages will have the capacity to be flexible and vary determined by individual need. These packages will have a restoration/rehabilitation focus. Where possible, processes that are currently effective would remain unchanged. Support Works will continue to be the agency responsible for monitoring client outcomes. For all clients, reviews can occur/be generated at any stage, as need dictates, at no longer than 12 month intervals.

Mid Central DHB

The Promoting Independence Programme (PIP) is a slow-stream rehabilitation programme run in Horowhenua. Clients to the programme are those who have experienced an acute episode in hospital and through the AT&R process are assessed as potentially benefiting from the rehabilitative programme. Otherwise, clients would have gone into a rest home. On the programme clients (who are mainly stroke patients) spend about 1 to 3 months in a residential rehabilitation facility, and then usually go back into the community, possibly receiving home based support.

MidCentral DHB has recently carried out an evaluation of the programme to consider if the programme is successful and if it is affordable for the DHB to provide such choice to its population.

The analysis was based on total size of 80 clients of the programme. A case was classified as successful if there was a delay in the client going into rest home, similar to the ASPIRE studies. The analysis also compared the actual costs incurred by each client at the NHI level with the residential cost avoided. A client's rehabilitation was considered cost effective if the combined costs of the programme and home based support services are less than the residential care costs avoided.

Actual and potential costs of residential care avoided were calculated. Actual costs avoided were calculated for 1 November 2003 to 29 September 2006 (the study cut-off date). Potential costs avoided were calculated based on assumptions made about future use of home based support and time in the community prior to entering residential care beyond 29 September 2006, for clients who had not died or had not entered residential care prior to that date.

The analysis found that the programme has a success rate of 87% and costs less than if the clients had gone into a rest home, therefore the DHB sees it as affordable and of benefit to the selected population of clients assessed as potentially benefiting from the programme.

Tairāwhiti DHB

Tairāwhiti DHB has piloted two community-based programmes – a Kaupapa Māori programme with Turanga Health PHO and “Evergreen Circle” with Presbyterian Support East Coast.

A qualitative evaluation of the pilots has been completed. A quantitative evaluation is expected to be completed in February 2007.

Based on initial findings, anecdotally, the main success factors appear to be:

- increased feeling of social connectedness amongst those who attended the groups. In respect of the Evergreen Circle, the sessions were relatively small (18) at each, which allowed participants to form close bonds;
- many participants expressed an increase in confidence as a result of attending the programme;
- attending was made easy because transport was provided;

- some functional improvements were noted e.g. participants reported a decrease in the number of falls they had, one person reported they no longer required a walking stick.

A key challenge noted by the Evergreen Circle programme was in recruiting appropriately trained staff, possibly because it was a new service – whereas the Turanga Health Programme built on an existing one using existing staff.

Following the end of the pilot it appears, at least initially, that the Turanga Health programme has been incorporated into 'business as usual' without additional funding. In contrast, the Evergreen Circle programme is being funded by Presbyterian Support Services, probably because it was not part of an existing service.

SECTION 5 – KEY LEARNINGS AND CHALLENGES

What do we want to achieve in New Zealand?

Given what we can learn from the research and experience outlined in this issues paper, we now need to consider how we can apply that knowledge in shaping services for older people in the future.

The key objectives underpinning any service changes or developments for effective and sustainable home- and community-based care are to:

- improve health outcomes for older people;
- support the Government’s direction of having integrated service provision and a greater emphasis on community-based services to support older people in their homes.

Increasingly, evidence and experience shows that community-based services can meet the needs of older people and assist them to remain in their own homes for longer. The DHB examples of ageing in place initiatives included in this paper also reflect an increased focus on service changes for effective care and support in the community.

The increasing focus on recovery, restoration, rehabilitation, participation, and independence across the whole continuum of care, and the emphasis on “working with” rather than “doing for” older people, suggest a rethink of the way both care in the community and residential care are provided.

There is some evidence that specific programmes can maintain function, and slow functional decline in older people.

In line with international trends and the New Zealand government’s strategic direction, the focus is increasingly on the provision of care and support services in the community. This change of emphasis does not mean that residential care services will no longer be required.

DHBs, as primary funders of health and disability support for older people, play a pivotal role in deciding the mix of community-based and residential care services that will be provided for their local populations. Such decisions have significant flow-on effects for other funders (e.g. ACC), service providers (including the paid workforce), older people and their family, whānau and carers. The Ministry of Health recognises that when determining the most effective service model for a DHB region it is not a case of one size fits all.

Key elements of successful care and support in the community

The initiatives evaluated in ASPIRE and provided in the DHB examples contain a number of common themes or principles. The following attributes appear to be key elements of successful community-based services and programmes:

- Services are older person-centred, which may include consideration of their social situation and active decision making by the older person and their family/whānau;
- There is a single point of entry to health and disability services;
- Needs assessment of older people is comprehensive and multi-disciplinary (preferably including the use of a standard assessment tool such as InterRAI), with periodic review and reassessment;
- A support plan is developed for, and with, the older person;
- For people with high and complex needs, there is a designated care manager for people with high and complex needs (also known as key worker, case manager) who co-ordinates the care package or service response;
- Flexible and responsive packages of care are provided to older people. These will tend to have a rehabilitative/restorative focus (i.e. regaining, maintaining or improving function). In circumstances where it is recognised that improvement is not possible, the goal of the person feeling 'in control' will remain;
- Support services are available for family/whānau and carers (including assessment and review);

These themes and principles are also reflected in the findings of international researchers (including Andersson and Karlberg (2000), Hardy *et al* (1999), Kodner and Kay Kyriacou (2000), Kodner and Spreeuwenberg (2002)). The following common features of successful integrated care arrangements have been identified:

- Identification and targeting of older people with high and very high needs;
- Case management/care coordination that spans time, setting and discipline. This includes care planning and ongoing patient monitoring and follow up;
- Comprehensive geriatric assessment spanning the full spectrum of service needs and professional discipline;
- Intensive, multidisciplinary teams including nurses, social workers and other health professionals, providing care;
- A set of professional values aligned with a geriatric philosophy;
- A single entry point for assessment and coordination (supports case management).

Challenges

Strengthening community-based care and changing the way services are currently provided presents a number of continuing challenges, including:

- Building workforce capacity which involves issues relating to pay, recruitment and retention, training and development;
- Establishing and maintaining an appropriate infrastructure, including information technology, to support services for older people;
- Addressing the variability in needs assessment across New Zealand;

- Looking at the way services are purchased;
- Provider capacity and capability;
- Family/whanau carer support needs.

Much work is already underway in these areas, but your feedback will help us move forward in addressing these challenges.

SECTION 6 – FOR YOUR FEEDBACK AND COMMENTS

The purpose of this issues paper is to share learning about care and support in the community for older people in New Zealand and provide a focus for discussions with key stakeholders about the future direction and possible options for community and home-based care services for older people.

The following set of questions is intended to provide a focus for the discussions. The Ministry welcomes your feedback and comments about the various issues affecting care and support in the community now and in the future; and particularly how they are likely to affect you and/or your organisation.

These questions are aimed at key stakeholders in the aged care sector, including DHBs, home care providers, residential care providers, Māori health providers, Pacific health providers, NGOs and consumer representatives.

Currently:

1. Please briefly describe your organisation or group (e.g. type of entity (government, not-for-profit, commercial); primary role of organisation or group; number of staff etc)

Note for DHBs and ACC: because data about your organisations are readily available, please record your organisation's name and go directly to question 2.

Note for consumer groups: please go directly to question 8.

2. Please indicate (by ticking the appropriate boxes in the table below) what types of health and disability services for older people are currently either funded and/or provided by your organisation or group.

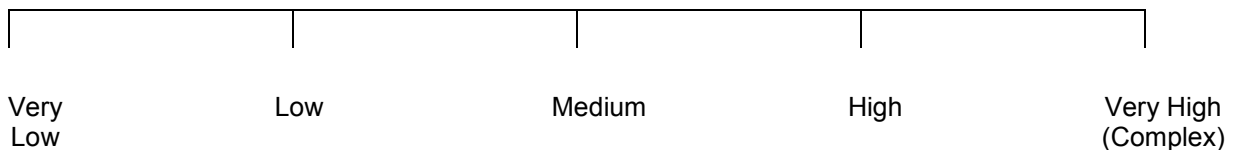
If you wish to add extra information about current services for older people, please use the space below the table.

Types of services for older people	Funded	Provided
Home-based support services – household management		
Home-based support services – personal care		
Home based support services – packages of care		
Home based support services – restorative/rehabilitative programmes		

Types of services for older people	Funded	Provided
Day care services or programmes		
Services designed to address social isolation		
Health promotion		
Case management		
Carer support		
Respite care		
Residential care (please list types e.g. rest homes as bullet points)		
Services specifically for Māori		
Services specifically for Pacific people		
Other (please describe)		

3. The scale below shows the five levels of support need for older people used in New Zealand.

Please indicate on the scale (either by showing % spread or by shading) at which level/s of need most of your health and disability support services for older people are currently being funded and/or provided.



4. What models (or programmes) of care and support in the community are already funded/provided or being piloted by your organisation or group?

- a) Have these shown similar trends to the ASPIRE findings? Please describe.
- b) What are the key elements of success of the programmes your organisation already has in place?

Note for DHBs: please indicate if this information has already been provided for DHBNZ's stocktake survey about DHB implementation of the Health of Older People Strategy.

5. What data/information does your organisation or group currently collect about health and disability services for older people that is the most useful to you? What gaps (if any) do you identify in respect of data/information collected about community based services?
6. What relationships does your organisation or group currently have with primary care providers and/or Primary Health Organisations? How do you expect these relationships to change with the shift to the integrated continuum of care?
7. What relationships (e.g. collaborative arrangements, joint projects or programmes) does your organisation or group currently have with other community organisations/groups and local government agencies (e.g. housing, transport)?
8. What service gaps (if any) does your organisation or group identify in respect of the current health and disability support services for older people?

Looking forward:

9. In future, what type of services do you think would need to be developed in your community to ensure a seamless continuum of care?
10. What is the shift to greater care and support in the community likely to mean for your organisation or group in terms of the list below?

Note: Please identify key issues, barriers and benefits to your organisation or group. How could issues or barriers be best addressed?

- a) Capacity issues?
- b) Workforce implications (training, recruitment and retention, pay rates)?
- c) Implications of increased acuity of older people entering residential care (e.g. workload, training and service models)?
- d) Contractual implications (funders, providers)?
- e) Ensuring quality of care in the community?
- f) Primary care services providers?
- g) Specific services for older Māori, older Pacific peoples, older people from other ethnic groups?
- h) Services for family, whānau and carers?
- i) Respite care services?

- j) Long-term residential care services for older people?
- k) Use of information technology?
- l) Relationships with community organisations/groups and local government agencies?

11. If your organisation or group has implemented, or is planning to implement, programmes to support older people to continue living in their homes:

- a) Have you evaluated the programme(s) cost effectiveness and/or their impact on health outcomes?
- b) If you answered yes to a), how did you evaluate the cost effectiveness and/or impact on health outcomes?
- c) If you answered yes to a), what were the broad findings from your evaluations?

12. Do you consider that the shift in service delivery focus would be effective for Māori? For Pacific peoples? Why or why not?

13. What would be a realistic timeframe for you or your organisation to implement changes or shifts in services that are required?

14. What do you see as the key role(s) of the Ministry in the process of shifting to care and support in the community?

Feedback

The Ministry encourages you to provide feedback and comments about care and support in the community, now and in the future.

Please forward your feedback and/or comments by 25 May to:

Email: HOP_careandsupport@MOH.govt.nz

Or:

Feedback – Care and Support in the Community
Health of Older People Policy team
Sector Policy Directorate
Ministry of Health
PO Box 5013
Wellington

Or:

Fax: (04) 496-2191
Attention - Health of Older People Policy team

Please let us know, by email or fax, if your organisation would like to be involved in stakeholder discussions, and nominate a key contact person.

Definitions of Selected Terms used in this Document

The terms below have the following specific definitions in the context of this issues paper.

<p>Ageing-in-place</p>	<p>Services to support older people in their homes (ageing-in-place) are defined as “services which give older people the ability to make choices in later life about where to live, and to receive the support needed to do so”. Such services enable older people to receive care and support in the community for longer, and can prevent or delay entry to residential care.</p> <p>In this issues paper, services to support ageing-in place are referred to as “care and support in the community for older people”.</p>
<p>Carer</p>	<p>A carer (or voluntary caregiver) is someone, usually a family member, who looks after a person with a disability or health problem, and who is unpaid for providing this service.</p>
<p>Community based services</p>	<p>Community-based services refer to services usually supplied in an older person’s home or within their local community.</p> <p>Services currently funded include:</p> <ul style="list-style-type: none"> • home based personal care (e.g. eating, dressing, bathing, toileting and mobility needs); • household tasks (e.g. laundry, vacuuming, dusting, dishwashing, bed-making, preparing meals); • similar services delivered in a residential care setting by external providers e.g. in an apartment or unit in a retirement village; • restorative care services. <p>Services excluded include:</p> <ul style="list-style-type: none"> • long-term aged residential care such as rest homes and continuing care hospitals. <p>Community-based services may be provided by:</p> <ul style="list-style-type: none"> • religious or welfare organisations; • private providers/companies; • informal caregivers (e.g. family or spouse).

Intermediate care	<p>This is defined as “services to either avoid preventable hospitalisation or support early discharge from hospital”.</p> <p>Intermediate care includes services that exist on the boundary between intensive health care (mainly hospitals) and community-based care.</p>
Integrated continuum of care	<p>An integrated approach to health and disability support services that is responsive to older people’s varied and changing needs. Providers co-ordinate their services, working closely with the older person and, where appropriate, with their family, whānau and carers to provide services that appear seamless to the recipients (Associate Minister of Health and Minister for Disability Issues, 2002)</p>
Levels of support need	<p>An older person’s assessed level of need is used to determine what type of support package will be required.</p> <p>The Ministry of Health has defined five levels of support need for older people in New Zealand. In brief, the five levels of support need are:</p> <p>Very low (1) – older person is able to live in their community and attend to activities of daily living (ADLs) with existing support;</p> <p>Low (2) – although coping, the older person’s ability to maintain life skills and abilities is compromised, and the carer’s capacity to provide support has changed or is insufficient to meet the needs of the older person;</p> <p>Medium (3) – the older person’s wellbeing and functional status has deteriorated and needs have increased, the carer is under considerable pressure and their ability to support the older person is compromised;</p> <p>High (4) – the older person’s ability to remain in their environment is compromised due to significant safety issues and more complex support needs;</p> <p>Very high/complex (5) – due to rapid deterioration, the older person’s support needs have significantly increased and current supports are no longer effective. The safety of the older person and the carer is at risk.</p>
Older people	<p>This issues paper focuses on people aged 65 and over, in line with the Health of Older People Strategy. The integrated approach to service provision discussed in the paper (and set out in the Strategy) can also be effective for</p>

	<p>people under the age of 65 who have conditions similar to those more commonly experienced in older age, notably Māori and Pacific peoples.</p>
<p>Packages of care</p>	<p>This term is used to refer to the individual packages of services put together for older people based on their assessed levels of support need and individual circumstances.</p> <p>Packages of care may draw together services from across the continuum of care, and will generally include community-based services. Packages of care usually include initial needs assessment, service coordination and goal setting; and review and reassessment as required .</p> <p>Services may include:</p> <ul style="list-style-type: none"> • household management e.g. cleaning, bed making, doing laundry • personal care e.g. help with showering • specialised support services e.g. stroke rehabilitation services • primary care services e.g. health promotion, GP visits • restorative care services • carer support • dementia day care • respite care • specialist assessments • Adaptations to the home e.g. shower rails • Admission to residential care
<p>Residential care</p>	<p>Four types of long-term residential care for older people are provided in New Zealand:</p> <ul style="list-style-type: none"> • Rest home care – allows some independence and is geared towards people who have moderate to high needs and/or some difficulty with mobility; • Dementia Unit – specialised unit that provides a safe environment for people with dementia requiring residential care. Referrals to this type of care are by specialist assessment. Dementia units are generally small and provide a secure environment to residents who have confusion, are mobile and need a safe environment; • Hospital level care – residents generally have high care needs. A registered nurse is available 24 hours a day. • Specialised hospital services (psychogeriatric services) – hospital level services for people with dementia with high

	<p>dependency needs and challenging/antisocial behaviour, or a combination of age-related disability and mental health condition with high dependency needs.</p> <p>Residential care facilities that receive funding from DHBs must be certified under the Health and Disability Services (Safety) Act 2001.</p>
Usual care	<p>This refers to a care and support package put together by a service coordinator in a NASC agency.</p>

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