

The New Zealand Home Health Association Inc

A Sustainable Cost Effective Model for Older Persons' Home Based Health & Disability Services

Context

Within New Zealand and worldwide, policy development and the resultant service delivery models that emerged in the 1980's largely assumed that both functional and mental decline were inevitable within the aging process and that therefore people needed to have tasks performed for them.

At the same time, the home based sector in New Zealand was emerging from a 'voluntary' mode and the thinking was that service specifications had to be very 'input based' and inflexible to ensure that control was maintained on providers who were perceived as largely amateurs.

Therefore the service model that emerged was one of a task-based, one size fits all, health model; a 'dependency' model, in that tasks were performed for people or to people. It was primarily aimed at older people and the needs of younger people with disabilities were slotted into this service model.

It is now obvious that the model that evolved, together with the way in which it is managed, clearly had inherent problems, including:

- Duplication of service provision
- Confusion over boundaries
- Duplication of assessment processes
- Poor coordination between services
- Multiple entry points for services
- Service gaps
- Fragmentation of services
- Difficulties in communication between services
- Service provision was constructed around contracts

The Movement for Change

The limitations of the existing service were first officially recognised in approximately 2002. This led to:

- Establishment of a standard (NZS 8158:2003)
- The Quality and Safety Project (Ministry of Health) completed 2004.
- Integrated Continuum of Care for Older People (Health of Older People Forum) 2004

- The Working Party on Services for Older People (Ministry of Health) completed 2005
- The Non Regulated Workforce in the Health & Disability Sector (DHBNZ) 2006
- Numerous studies on Support Worker wages and conditions ('Low paid Workers Initiative', 'Fair Travel', Transporting Clients etc)
- Numerous studies about worker qualifications by MoH, DHBNZ, CareerForce.
- Two Parliamentary Health Select Committee Reports into Support Worker wages and conditions
- Ongoing workforce needs and development programmes by Ministry of Health, DHBNZ, and individual DHB's
- Ongoing service development programmes by MoH, DHBNZ and individual DHB's

While these may all have resulted in some minor changes they failed to address the fundamental changes necessary as:

- Reports are frequently published, without subsequent effective action; following a change in government agency personnel, the issue may then be subject to another study some years later
- There is a tendency to study issues individually and implement change without a common vision as to the total service, or how issues inter-relate.
- There is no requirement for DHB's to follow or implement actions resulting from reviews by either MoH or DHBNZ; accordingly we are implementing 21 increasingly disparate services for older people.

This process has been hugely wasteful of the time and resources of government agencies and providers alike.

There is no common vision; not just in general terms but in detail, as to the effective, efficient and fiscally responsible system we wish to evolve.

A clear consensus has emerged that, while the ageing process cannot ultimately be denied and does involve decline, this is neither a linear progression nor is it consistent by individual; accordingly it should not underpin the service model used. There has been growing acceptance for a system that maximizes client independence through person centred and capacity building approaches to service delivery, with outcomes that:

- Changes the perception of communities, the workforce and the clients themselves as to the functional capacity of older people and those with disabilities.
- Improves or maintains clients' functional capacity, such that their need for recurrent services is delayed or reduced.
- Improves or maintains the client's quality of life by maximizing their capacity to interact with their wider community.

This outcome approach to service delivery also encapsulates the 'integrated continuum of care' concept. At the heart of an outcome based model is the client's

ongoing interaction with their community. We recognise that this poses substantial questions in regard to boundaries of service, coordination between services and funding silos which need to be addressed.

Changing only the delivery model of care within home based services will not automatically overcome all of the inherent problems of the traditional model. In order to effect meaningful change, the whole support structure and mode of integration of services must be addressed. In our haste to be seen to be undergoing change we are concentrating on pilots and projects, and not on developing a complete system.

Unless the system is first developed, there is a strong probability that services developed in isolation will:

- not be sustainable for either government or providers
- continue to support duplication of services
- continue to support silo development
- not be responsive to the support of future generations

This will ultimately slow down and frustrate the development of homebased services.

The Current Situation

Contracting

Services are funded and contracted via 21 District Health Boards. At devolution the DHB's accepted and rolled over existing common contracting and service specification frameworks. However over time there is an increasing move for individual DHB's to create their own frameworks based on their perception of population and funding ability. The risk for the industry is increasing fragmentation with different cost models.

Negotiations between DHB's and providers does not include pricing; this is deemed non-negotiable by the DHB and the limited bargaining power of providers leaves them with only the options of accepting or withdrawing from the market.

Providers have repeatedly requested that costing models be established, throughout the change process, to establish the sustainability of proposals for both the DHB and the provider. These requests are declined as it is perceived that such an approach would increase provider bargaining power. As a result services are being implemented with no appreciation as to their long-term sustainability.

National providers are required to respond to RFP's and negotiate (on issues other than price, which is set by the DHB) with individual DHB's for differing specified services for the same basic delivery. The cost, to both DHB's and providers, of 21 differing versions of the same service is unnecessarily high.

Home and Community Support Sector Standard

A Standard (Home and Community Support Sector Standard NZS8158:2003) was developed in 2003 under the sponsorship of MoH and ACC. This has not been formally adopted, although the majority of providers have gained accreditation to this Standard. DHB's are increasingly making compliance to this Standard a contractual obligation; however others state that they have no intention of doing so.

The cost for the adoption of this standard has not yet been quantified and the burden for adoption has rested with the provider.

Costs and pricing of service delivery

District Health Boards are increasingly adopting 'restorative' models of service; these all differ and the majority of these services have been implemented without any consideration as to the sustainability of such services for the Providers. In fact a number have chosen to implement pilot restorative programmes for their entire over 65 client base; these have been implemented with the financial goodwill of providers and are clearly not sustainable at current pricing.

Much of that advocated and implemented to date, will not be affordable if extrapolated across a total client base with varying levels of need. Restorative care is more expensive than the current services to deliver into a home based setting; and at the higher client need level considerably more expensive – it needs better trained and remunerated staff, greater levels of case management, coordination, planning and supervision together with an increased infrastructure to support restorative activities.

Savings will be achieved within the broader health system and therefore there is a need to ensure that the system developed gives the maximum benefits for the minimum level of cost increase. This is **not** a matter of simply packaging up all existing services in a different manner within the current home based support funding – such an approach is doomed to failure.

Costs are, or will be, impacted for Government by:

- Segmentation of policy work across funding agencies
- Each individual DHB consulting on, implementing and maintaining service specifications and contracts. While these are undoubtedly informed by other DHB experiences, they all differ.
- Some services implemented are not sustainable for the provider as they have substantially increased costs and this has not currently been reflected in pricing. This will mean that pricing must increase or the model changed at substantial cost
- Individual DHB auditing and compliance requirements

Costs have increased for providers as:

- They are required to meet multiple contract conditions and reporting requirements

- They are required to meet multiple standards, service specifications, staff training and supervision requirements.
- Prices paid by DHB's currently vary by up to 24% and do not reflect the service contracted; often the lower paying DHB's have the higher cost specifications.
- Providers are required to apply unnecessarily large amounts of management time in order to comply with multiple audits by DHB's; many DHB's auditing the same national systems (e.g. governance, administration, finance)

Needs Assessment & Service Coordination

NASC Agencies generally receive referrals, undertake personal assessment of clients and refer the service delivery to the selected Provider¹. Ongoing client reviews are undertaken by the NASC.

NASCs' criteria for entry to Services for the Older Person vary markedly, or are interpreted markedly differently, throughout New Zealand.

Providers also, in accordance with their obligations under both Health & Safety and their own risk management, undertake an assessment or appraisal of client needs, with ongoing reviews, in order to establish their support plan and health and safety plan. We therefore have a duplication of visiting and assessment activities that are often unnecessary, wasteful of time and expertise and are intrusive for the client.

This approach:

- Is wasteful of valuable personnel resource
- Creates confusion over boundaries
- Does not address the wider issues relating to poor coordination between services, multiple entry points for services, service gaps or fragmentation of services
- Is creating disparate entitlements for entry to services for Older People, based on their geographic location

Training co-ordination and supervision

In the 1980's support provided for clients was based on task and these tasks were prescribed closely. With the greater changes to the health market the support provided into the community is greater in acuity. This has been recognised by the industry and various training courses have been developed to help meet this need. Although there is industry recognition of the need to provide a professional and more highly skilled workforce the funding approaches to the provision of training has developed ad hoc with limited recognition as to the cost of training provision for providers. The present contacting price is considered by funders as providing a

¹ The notable exception to this procedure is Capital Coast DHB who utilise a more comprehensive Care Coordination Centre approach; a similar approach to this is currently being implemented by Auckland DHB.

training cost component. This component is to cover courses that range from entry to work through to NZQA level 4 training.

The increases in client acuity have resulted in the need for increased supervision of support workers and clients. Often this supervision has required the skill and knowledge of health professionals such as registered and enrolled nurses. There has been a failure by the funder to recognise that the cost of services goes beyond the cost of a support worker.

Suggested Approach

It is suggested that the following actions would provide a more cost effective, appropriate and responsive Home Based Service for Older People throughout New Zealand.

- Adoption of Home and Community Support Sector Standard NZS 8158:2003 on a national basis.
- Adoption of minimum training standards for support workers on a national basis. Such minimum standards to be related to the level of acuity of the client to receive services – not a minimum for all support workers
- Increased consistency in contracting for home based Services for Older Persons
- Increased flexibility in service provision supported by contracts and funding.
- Approval of 'Designated Auditing Agencies' for a single audit approach
- Development of a costing model as a basis for negotiation of pricing, terms and conditions of contracts
- Streamlining of access to services through a co-ordinated process which avoids duplication
- Services contracted to utilise skills of providers, without unnecessary duplication, in a manner that minimises risks for Government
- Services be contracted, funded and delivered in accordance with broad need categories, rather than a 'one size fits all' basis

Example

One such approach for home based services may be to develop three models of home support services, by level of need, all within a goal based outcome focused framework.

Clients could be telephone triaged by the Integrated Care Coordination Centre into the service as follows:

For Level 1 clients - those requiring knowledge and skills for supported self care, the referral could be directly to the provider. The provider could assess, provide education to enable the client to self support with the minor assistance as required.

For a Level 2 clients, that is an individual with at risk condition, or is unstable, or who without a structured support could deteriorate, the referral could again be direct to the provider for assessment and the provision of services under a provider case managed restorative model.

For Level 3 clients, being individuals with a high intensity of need or those having multiple needs, the assessment could be carried out by the Integrated Care Coordination Centre utilizing tools such as InterRAI. Service provision is then provided under a goal based model under a case manager within the provider organization. The provider case manager remains in close contact with the Integrated Care Coordination Centre case manager in regard to integration of services, changing needs and goal achievement outcomes.

Transition to a National Sustainable Model

The current transition for home based Older Persons Services, from a 'task based' to an 'outcome based' model has been six years in the making. To date this has achieved:

- Disparate models across 21 DHB's
- Implementation of non-sustainable models
- Inequity in service entry criteria
- Lack of consistent standards
- Many services that continue to operate on a 'task based' approach

A speedy transition to a nationally consistent, quality based, responsive and sustainable service will only be achieved when the design, implementation and oversight of the service is undertaken on a national basis.

The individual elements for such a system largely exist within pockets throughout the current services. Accordingly such a transition could be speedy if there was a willingness to review the current approach of total autonomy to individual DHB's in regard to such services.

NZHHA Executive Committee
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