The Hearing Aid Podcasts

Episode 7.07 Show Notes
Models of Care

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1.

Social Media

Things seen on social media + discussed in episode (all guests can add)
Aoife:
https://www.bgs.org.uk/policy-and-media/patients-with-difficulty-swallowing-being-kept-nil-by-mouth-unnecessarily-says

Iain:
https://journals.sagepub.com/doi/full/10.1177/1471301219838086

ABC model dementia and admiral nurses.

Main Show Notes:

Patient:

Mr Jones is a 85 year old man who has been struggling over the last 4 years with worsening shortness of breath and diabetic control. He has been in and out of hospital a few times with exacerbations of his symptoms. His mood had reduced and he has recently been diagnosed with depression.
He lives at home alone with a small care package (help with his shopping and his washing etc).

He becomes more breathless and calls his gp:

Question here:

What model of care is there for him?

What should be done?

Learning Outcomes

- **Knowledge**:
    - Develop and understanding of different models of care
    - To be aware of potential different models of care (ways of organising services) for older people in the UK
- **Skills**:
    - To be able to suggest alternative approaches to providing care to older people
    - To know how to find you single point of access for intermediate care
- **Attitudes**:
    - To understand models of care may change depending on the needs of the location and local patients and one size does not fit all.

Definitions:

A 'model of care' broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, and in the right place.

NSW Agency for Clinical Innovation. Understanding the process of developing a model of care. 2013. Page 3
https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf

Practical Definition

So why talk about healthcare models?

- Our current health systems were designed and implemented in the 1940s, in a post war world when life expectancy for men was 66 years and women 71 years.
- Now - we are living longer with more complex healthcare needs. Life expectancy is now 79 for men and 82 for women and increasing by 5 hours per day!
    - It costs 5 times more to look after an eighty year old than it does a 30 year old and so we must consider different models of care to address our changing healthcare needs.

Links to previous podcast on multiple morbidity (3.1) and influence of one disease on another, which influences treatment.

- This ageing population puts an increasing dependency on health and social care which has led to the importance of a shift from a problem-based, disease oriented model of care to a goal-orientated integrated model. A proactive, empowering model in which goals are set with the individual.
- This shift set against a background of financial difficulties and the importance of providing quality health and social care support, which has led to a move away from medicalised approaches to an emphasis on a holistic, multi-disciplinary and person-centred approaches to care.

Blom, J. Den Elzen, W. van Houwelingen, A.H. Heijmans, M. Stijnen, T. Van Den Hout. Gussekloo, J. 2016. Age and Ageing. 45. Pp 30-41.

If we initially consider overall healthcare systems.(covers funding and macro level dynamics).

There are four basic models of care that are used worldwide on which healthcare services are built.. The Beveridge Model, from which the NHS is structured, The Bismarck Model, The National Health insurance Model and The Out-Of-Pocket Model.
To explain these in more detail:

1. **The Beveridge Model**
    a. Named after William Beveridge who designed the NHS. Healthcare is provided and financed by the government through tax payments
    b. Found: UK, Spain, Scandinavia, New Zealand, Cuba

2. **The Bismarck Model**
    a. Named after Counsellor Otto von Bismarck, this was the healthcare system which was put in place in unified Germany. Similar to the american system in that it uses an insurance system, usually funded via payroll deduction from employer and employee, but in this system everyone must be covered and the insurers don't make a profit.
    b. Found: Germany, France, Belgium, The Netherlands, Switzerland, Japan

3. **The National Health insurance Model**
    a. This uses elements of the previous two systems. It uses private healthcare providers but payment comes from a government run insurance programme that all citizens pay into.
    b. Found: Canada, Taiwan, South Korea

4. **The Out-Of-Pocket Model**
    a. Only about 20% of the worlds nations have an established healthcare system. Those who don't, generally have to pay to see a healthcare

professional each time they're needed with millions not seeing anyone throughout their lifetime
http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php

Models by setting (Discuss how this would be for Mr Jones for a few of these maybe people from each service to say what they would offer him - may take too long though)

3 areas, in hospital, in community and the interface of these two.

1. Within hospitals these include (we will focus more on the 'downstream services':

a. Hospital-wide (Hospitalist (USA) vs primary care vs specialists)
   i. **Mr Jones** admitted to hospital - his own doctor directs his care vs hospitalist vs acute medicine vs geriatric team
b. Generic
c. Emergency department
   i. **Mr Jones** Sees an ED specialist how has not met him to decide to admit or nothing
d. Acute Geriatric Units
   i. Evidence for CGA in episode 1.1 location based services work.
   ii. **Mr Jones admitted to a DME ward etc**
e. Comprehensive geriatric assessment of acute admissions to hospital
   i. Post ED
      1. There is no clear evidence of benefit for CGA interventions in frail older people being discharged from emergency departments or acute medical units. However, few such trials have been carried out and their overall quality was poor. Further well designed trials are justified.
https://www.ncbi.nlm.nih.gov/pubmed/21616954

ii. **Mr Jones** d.c home with follow up planned.

f. Consultation services in hospital
   i. **Mr Jones** admitted to resp ward with geriatrics consultation (either via referral or from an automated system - eg. frailsafe)
   ii. **OPALS services**
      1. Many examples of this.
         a. Geriatric teams putting services into:
         b. AMU - https://academic.oup.com/ageing/article/36/6/670/40336
         c. Orthopaedics - NHFD
         d. Surgery - POP

g. Inpatient rehabilitation
   i. **Mr Jones** initial acute care then dc to rehab

h. Geriatric medical service

2. Community / hospital interface (will talk more about this later)

a. Models of care at the interface are variously labelled, most commonly as transition care or intermediate care. Most of the evidence has come from the care in the postacute phase

b. Discuss interface
   i. **Methods**: a pre-post cohort study of the impact of embedding CGA within a large ED in the East Midlands, UK. The primary outcome was admission avoidance from the ED, with readmissions, length of stay and bed-day use as secondary outcomes.
   ii. **Results**: attendances to ED increased in older people over the study period, whereas the ED conversion rate fell from 69.6 to 61.2% in people aged 85+, and readmission rates in this group fell from 26.0% at 90 days to 19.9%. In-patient bed-day use increased slightly, as did the mean length of stay.
   iii. **Discussion**: it is possible to embed CGA within EDs, which is associated with improvements in operational outcomes.

iv. **Mr Jones** - seen in ED by geriatrician - ? admit or not… early CGA there in ED or soon on d/c

Conroy et al. A controlled evaluation of comprehensive geriatric assessment in the emergency department: the 'Emergency Frailty Unit'.Age Ageing. 2014 Jan;43(1):109-14.

Intermediate Care/reablement:

This process of more person centred care is taken up in the NICE guidelines for intermediate care services in the UK,

They need to:

- develop goals in a collaborative way that optimises independence and wellbeing
- adopt a person-centred approach, taking into account cultural differences and preferences.

Represents a range of services on a spectrum::

- home-based intermediate care,
- reablement,
- bed-based intermediate care and
- crisis response

all should be made available locally.

Locality teams must:

- ensure that intermediate care teams work proactively with practitioners referring into the service
- a single point of access for those referring to the service
- a management structure across all services that includes a single accountable person, such as a team leader
- a single assessment process
- a shared understanding of what intermediate care aims to do
- an agreed approach to outcome measurement for reporting and benchmarking.

https://www.nice.org.uk/guidance/ng74

The aim of these services is to:

- promote faster recovery from illness;
- prevent unnecessary acute hospital admissions and premature admissions to long-term care;
- support timely discharge from hospital; and
- maximise independent living.

Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks.

3. Community

a. Day Hospital;
   i. **Mr Jones** admitted in 'step up' fashion to intermediate care bed
   ii. Originated in the United Kingdom in the 1950s
   iii. Dedicated outpatient service providing specialized, interdisciplinary, ambulatory, and usually rapid access geriatric medical, nursing, and rehabilitation care to community-dwelling older patients.
   iv. Day Hospitals represented an evolution in primary and secondary level ambulatory care models for older people with complex needs. Those attending Day Hospitals receive and benefit from CGA, individualized multi-domain assessment by a multidisciplinary team using validated scales and interventions that reduce adverse outcomes, hospital admission, and length of hospitalization
   v. The most recent change in Day Hospitals is a shift toward specialty services, clinics, and ambulatory investigations. Paralleling this change, the relatively new construct of frailty has begun to replace historical models of geriatric care and is increasingly being used in Day Hospitals to select and risk-stratify attendees.

Can the Geriatric Day Hospital Act As a Hub for Services for Older People across the Spectrum of Ageing from Active Ageing to Advanced Frailty? R O'Caoimh, S Kennelly, D O'Shea - Frontiers in medicine, 2018

b. Nursing Homes, residential care establishments
c. Primary Care
d. Patients' home

This is a really good report published by NHS Scotland

https://www.nhshighland.scot.nhs.uk/Publications/Documents/Our%20Older%20Population/Models%20of%20Geriatric%20Care%20(Oct%202012).pdf

Despite the recent drive for further integration of services for an individual patient there is still a degree of silo working and no clear linked up pathways..

Historically medical care has focused on single episodes of illness, which does not meet the needs of our older patients with complex needs (Street, 2004. cited in Peek et al, 2007).
There has been much emphasis on the importance of a range of services being formally integrated into multidisciplinary teams to enable them to successfully:

- Screen older people
- Provide appropriate interventions
- Assure continuity of care

A collaborative approach is often seen as the best way to provide different models of care. However there is a general lack of agreement amongst professionals of the elements that make up a collaborative approach.

Bower, P. Gilbody, S. Richards, D. & Sutton, J. 2006. Collaborative care for depression in primary care: Making sense of complex interventions: systematic review and meta-regression. British Journal. Of Psychiatry, 189. Pp. 484-493

Integrated care: aims to improve patient experience and achieve greater efficiency and value from health and social care delivery systems.

- It aims to address fragmentation in patient services, reducing confusion, repetition, duplication, gaps and delay in service provision leading to better coordinated and continuous care for the individual.

It tries to achieve this by:

1. Supporting the coordination of services, with a particular focus on those at risk of developing acute illness and being hospitalised

2. Providing more care in the community including in a person's home, in partnership with social care, and the voluntary and community sector

3. Ensuring a greater focus on population health and preventing ill health

4. Allowing systems (i.e. health and social care) to take collective responsibility for how they best use resources to improve health results and the quality of care being received, thus avoiding trips to A&E.

Example

NHS England: Vanguards

- In 2015 NHS england set up a series of collaboratives to trial new care models.
    - Initially in 3 areas:
        - integrated primary and acute care systems (joining up GP, hospital, community and mental health services)
        - enhanced care in care homes (offering older people better, joined up health, care and rehabilitation services)
        - multispecialty community providers (better integration of various strands of community services such as GPs, community nursing, mental health and social care, moving specialist care out of hospitals and into the community).

    - The programme has since been extended to 50 vanguards and plays an integral part in the NHS Five year Forward Plan.
- Data shows these programmes have had a direct affect on acute admissions:
    - Growth of emergency admissions in areas **with** the integrated primary and acute care systems of 1.1% and multispecialty community providers of 1.9%
    - compared with non vanguard areas where it was 3.2%.

https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

- A report from the National Audit office in July 2018 has shown that the funding needed to continue these initiatives is often being redirected to relieve short-term financial short falls and therefore not always finding its intended target.

https://www.nao.org.uk/report/developing-new-care-models-through-nhs-vanguards

In addition; in 2012, the NHS Commissioning Board commissioned National Voices to develop a narrative for the benefits of integration utilising the experiences of patients, service users, carers and organisations which lead to the creation of "I statements" example being:

- I work with my team to agree a care and support plan.
- I know what is in my care and support plan.
- I know what to do if things change or go wrong.
- I have as much control of planning my care and support as I want.
- I can decide the kind of support I need and how to receive it.
- My care plan is clearly entered on my record.
- I have regular reviews of my care and treatment, and of my care and support plan.
- I have regular, comprehensive reviews of my medicines.
- When something is planned, it happens.
- I can plan ahead and stay in control in emergencies.
- I have systems in place to get help at an early stage to avoid a crisis.

https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf

Some examples of integrated care approaches:

- People with urgent medical needs getting same-day appointments at centres, which bring relevant care professionals together under one roof.
- People over 60 with two or more long-term conditions referred by their GP to an 'extensivist' team with a range of clinical and support skills to develop a personalised care plan.
- A 'virtual ward' which helps keep older people out of hospital. Doctors, nurses, social care staff, physios and others discuss patients who are put on a rolling 'virtual' list each week if thought to be at risk of hospital admission.

https://www.england.nhs.uk/wp-content/uploads/2018/06/breaking-down-barriers-to-better-health-and-care.pdf

Worked example: Older people with mild to moderate depression and the role of nurses:

Older people can often suffer from depression, affecting around **22%** of men and **28%** of women aged 65 years and over, yet it is estimated that **85%**of older people receive no help at all from the NHS.
https://www.mentalhealth.org.uk/statistics/mental-health-statistics-older-people

Older people with mild to moderate depression were 38% more likely to be admitted to a nursing home.

An paper published in 2013 summarised some of these approaches in older patients with depression

They found three collaborative approaches all utilising a multi-disciplinary approach (including Nurses, physicians, psychiatrists, social workers, psychologists:

- **The Collaborative Care Model** – the key elements of this approach are:
  - Service user seeks help via primary care (normally GP)
  - Common definition of the problem
  - Development of a therapeutic alliance between the team and the service user, taking into account their preferences
  - Proactive follow up

- Outcomes monitored by a nurse (normally called a 'depression care manager' who maintained the relationship with the individual/monitored progress).

- **Community Health Team approach** – described as a specialist care approach in an addition to primary care. Key elements:
  - Visit at home
  - Multidisciplinary approach to care and treatment
  - Involves monitoring and prescription of medication
  - Provides psychological intervention and supportive psych-therapy
  - Focus on continuity of care.
  - Can provide consultancy to primary care

- **Psychogeriatric Assessment and Treatment in City Housing (PATCH)**
  - An outreach programme for lay people in close contact with the older person, who are trained to screen individuals at risk of depression.
  - Acts as a gatekeeper to recognised and refer people to a specialist nurse
  - Psychiatric nurses act as consultants or supervisory to the lay person and provide primary care to the individual
  - Psychiatrist are consultants for the psychiatric nurses who conducted an evaluation and treatment in persons own home.
- Individuals reached were more likely to live alone, be widowed or divorced and socially isolated
- Differs in approach as has a lower referral threshold

Dreizler, J. Koppitz, A. Probst, S. & Mahrer-Imhof, R. 2013. Including nurses in care models for older people with mild to moderate depression: an integrative review. *Journal of Clinical Nursing*. 23. pp 911–926

Person-centred models of care for older people in an acute care setting - boundary blurring:

- Models which take a more holistic, person-centred approach, recognising the centrality of the person, are now considered the gold standard internationally gives patients more empowerment in their healthcare.

- There is a recognition that this requires trust to be developed between the person and the practitioner.

- One Australian paper, looks at how a move towards this way of care provision requires ALL individual's working with older people to develop their knowledge and skills, which will help to transform the culture of organisations providing care and support.
    - This involves supporting people to critically reflect on their practice, which may sigmatism, discriminate or stereotype against older people. The aim being to remove 'ageism' from decision making, which can include using action research and critical friends.
- Multi-disciplinary working is not a new concept, it emerged in the 1970's. However person-centred approaches to care require the boundaries between the different professional's to be removed as these can be obstructive to the way the team works with the individual (Dunn, 2006. Cited in Peek et al, 2007)

Peek, C. Higgins, I & Milson-Hawke, S. 2007. Towards innovation: The development of a person-centred model of care for older people in acute care. *Contemporary Nurse.* 26 (2) pp. 164-176

Back to Mr Jones for round up - KEY POINT - it's all about what HE wants - to deliver person centred care....

Curriculum Mapping

This episode covers the following areas (n.b not all areas are covered in detail in this single episode):

- NHS Knowledge Skills Framework
  - Core: Service improvement - level 3
  - Core: Quality - level 2
  - G2: Development and innovation- level 2
- Foundation curriculum
  - Recognises, assesses and manages patients with long term conditions
  -
- Core Medical Training
  - Managing long term conditions and promoting patient self-care
  - Management and NHS structure
- GPVTS program
  - 3.05 Care of Older Adults
- Geriatric Medicine Training Curriculum
  - Principle LOBs: Assess a patient's suitability for and provide appropriate care to those in long term (continuing care) in the NHS or community
  - 3.2.6 Planning Transfers of Care and Ongoing Care Outside Hospital
  - 3.2.8 Management
  - 50. Intermediate Care and Community Practice
- PA matrix of conditions
  - n/a specifically on this episode

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