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EARLY ACCESS TO SERVICES BY OLDER PEOPLE

Dear Social Service Practitioners,

Start with how Older People want to Live

A common theme among students and practitioners about service delivery is how to better integrate services from the client's perspective. Many would like to see better integration of services, and even more so, to see integration begin early in the planning of services. Some would also advocate that it is time to have ways in which clients, including older people and their family carers, are listened to. This can lead to making adjustments to the types of services they require and use, and how they are delivered.

Such discussions can lead to a better coordination and integration of services that are structured in a more holistic approach in order to meet the often complex needs of some families and older people. What then are some of the challenges to achieving integrated services, especially those that arise from the funding and legislative base of the services? Are there lessons that we can learn as we begin to unpick the complexities of integration at the practice, managerial, systemic and political levels?

The Principles behind Integrated Services or Care for Vulnerable Persons

Let's begin by taking a closer look at services for older people. And what better way than to draw on the 1991 UN Principles for Older People[1] which states the principles for working with elderly. The principles include independence, participation, care, self-fulfilment and dignity.

They were designed to empower those working with older people and to help practitioners convey to the elderly that they are accountable for the way in which services are delivered. How does this translate into practice in the planning and delivery of services and in the service experience for older people? For older people, the integration of acute and community services results in a less traumatic experience when the two separate segments are better aligned.

1991 UN Principles for Working with Elderly

1. Independence
2. Participation
3. Care
4. Self-fulfilment
5. Dignity

Certain practices have shown to be helpful in improving the productivity and outcomes of care for older persons. Firstly, get in early to offer help to promote healthy living. Secondly, invest in alternatives to acute hospital and community aged care. Thirdly, provide acute care by specialists with background in geriatrics and multi-disciplinary/ trans-disciplinary approaches. Fourthly, engage in coordinated community services that have clients at the centre.

1 United Nations. (1991, 16 Dec). 46/91. Implementation of the International Plan of Action on Ageing and related activities. Retrieved from http://www.un.org/documents/ga/res/46/a46r091.htm

1 What does it mean to get in early?

In essence, this is about picking up from assessments instances where older people need help in the community and then planning what will enable them to continue to look after their own health, prevent falls, stay active and remain independent. All these in addition to being able to maintain a harmonious family relationship and connectedness in the community. The greatest challenge is often in having a single assessment instrument which can distract one from the immediate possibility of giving older people good information that they can use as part of maintaining their independence. The emphasis here is good information that is understandable from a user perspective and not from a domain expert perspective. There can be a long term goal of having an assessment framework to develop electronic shared assessments for health, social care and the community agencies. This will aid in the assessment and response to the needs of older people. However, this may take a long time which would delay older people from receiving good information.

INFORMATION

What might be good information? It is information that is easy for the older people to understand which can lead them to receiving help early to counter threats to health, independence and well-being.

Such information would cover:

- seeing, hearing and communicating;
- looking after oneself;
- getting around;
- safety and relationships;
- accommodation and finance;
- mental health and well-being; and
- staying healthy.

We could aim for self-assessment which is easy to complete and understand. So what all of us who are in contact with older people can do is to give good information, help the older people or family members use it so that they can then decide how they might adjust their daily activities accordingly. In some instances, the ideal and good practice is to have an assessment and then put together the service response based on the priorities of the older person. In many cases, older people can have their needs met through good advice and good community support which is delivered by social agencies.

With the growing number of older people, the involvement of the community is key to ensuring that whatever is put together is sustainable. Most practitioners will advocate for focusing on reducing morbidity and extending the healthy active life in old age, and therefore, a supportive community that enables older people to remain in a familiar environment and maintain their connections.

2 So what are alternatives to acute hospital care?

A relatively small proportion of older people will require acute hospital care and it is good to keep it to appropriate and episodic acute care. The challenge is enabling appropriate assessment, follow up and care in the community which requires coordination and good communication among the different parties involved in the lives of the old person. It requires a close partnership with adult social care and primary care. It is understandable that it is easier and faster to integrate acute and community services when these are being run by a single provider. In the case of Singapore, this is largely coordinated by the Agency for Integrated Care.

Nevertheless, the challenge still lies in helping families and the public to appreciate that acute care should be timely and appropriate and that it is often not the best, first port of call option for ailing and fragile older people. There is a need to emphasize short stays at acute hospitals for those who do not require the full diagnostic and treatment services of an acute hospital. Where possible, it is useful that daily ward rounds bring together key persons of “one practice” or “one team”, however we compose it, rather than several individuals on a not-joined-up list of contact points.

Discharge to intermediate and long term care facilities, e.g. day rehab / day care centres / nursing homes or care at home, must be well supported. Discharge can be better facilitated if there are regular inputs from a consultant geriatrician in a multidisciplinary case conference. While there is recognition for and supported investment in home-based community services, there still remains a challenge to grow it as it relies significantly on trained manpower. It is the community teams that provide support to prevent unnecessary acute admissions especially in cases where intense, short term support is all that is needed to keep the patient at home. However, putting together this intense support requires providers to work in a more "boundary-less" way.

There is an increased emphasis on tapping on natural support systems and step-up community-based support. This is made possible by more local GPs being involved in the follow up process with community services. This allows more complex cases to be managed closer to home. Wherever possible, it should adopt a multidisciplinary approach with access to secondary care support and advice. The role of GPs/ family medicine in such an environment will become more crucial and thus, the training of GPs must be done with this growing role in mind.

There are further instances where acute admissions can perhaps be minimised. This can happen if there is a way where adult social care services can work with immediate care by a local team that has the capacity to provide a rapid (two-hour) response to a frailty crisis with an older person. Both the older person, the care givers and the community service providers will be more confident of playing a larger role when they know that such a crisis response is available.

3 Acute care by specialists familiar with geriatrics

Some have suggested that with the growing number of older people, it will be helpful to have "old age specialist teams" that are available at the medical admissions unit. This may reduce admissions and long term stay if what some call, "consultant-led old-age specialist assessment" is available at the pre-admissions stage or even at the community level. This could also mean that some early assessments would have to be made before an older person is moved into and "drift" in the system. This could result in improved productivity with less down time in terms of transfers of wards and a better patient experience. In the case of admissions, it could mean earlier discharge to community-based care.

4 Community services that have clients at the centre

The design of services to meet the needs of older people can be complex. More integrated care is correctly seen as the right general approach. What is challenging though is the difficult discussions about risks for older people and the ownership of this integrated approach towards supporting older people living in the community. For such integration to work, it is essential to build relationships and trust through inter-agency work on strategy, operations, care plan and sharing of information. It is about multi-disciplinary, if not trans-disciplinary work, that requires sustained leadership from all parties. What will motivate us to focus on good outcomes for older people is the productivity gains for our agencies and the better deployment of expertise and manpower. It is about an environment that aligns and, over time, integrates health and social care provision to ensure better outcomes at lower cost.

Principles behind integrated services

So how are the principles of independence, participation, care, self-fulfilment and dignity applicable across working with various clients who are vulnerable? They are applicable as they are aligned with the values and principles of social work practice which support involvement, self-determination, respect and dignity of the human being. There should be greater efforts to inform and work more deliberately with those who receive services. From another perspective, it is about conveying to users that providers are accountable for the way in which services are delivered. It does sound like a tall order, but good practice and good public service do demand that of professionals, practitioners and even those who offer community service.

The principles behind integrated services help service providers no matter what expertise, resources, attributes and goodwill we bring to the helping relationship. They remind us that we should be mindful that there is accountability when we are involved in the lives of others and especially those who open up their lives for us to work with them. There will be challenging situations but we should stay focused on getting the outcomes.

Application in early intervention for children and youth services

The overarching guiding principle in many services can also be summed up in a phrase, "it's all in the relationship". Clinical, collaborative, and administrative efforts can be relationship-oriented, focusing on positive parent-child, family-staff, staff-agency, and agency-agency interactions. The work with families therefore depends first and foremost on positive rapport and trust building with families through an ongoing, consistent, and supportive professional relationship which will facilitate disclosure of behavioural issues over time.

Integration often involves a strength-based approach based on a family needs assessment, and the provision of comprehensive and responsive services over time to allow for sufficient dosage levels. There is less of a traditional "deficit" approach in delivering services for young children and a shift to a more family-centred model of care. In one form of an integrated approach, there is a philosophical shift from deficits to strengths, from control to collaboration, from an expert model to a partnership model, from gate-keeping to sharing, and from dependence to empowerment.

This approach supports young children's development and well-being, supports family decision making and care giving, fosters families' independence, respects children and family choices, builds on child and family strengths, and involves families in all aspects of the evaluation, planning, and delivery of services. It recognises the importance of relationships, the need to identify families-in-need early, and agrees that integrated services must involve a comprehensive and holistic system of care. Programmes, staff, and the interventions must be flexible and must accommodate the needs of the population being served. It builds on whatever integration in services that already exist and explores the concept of "value added" services.

Cultural competence

One way in which agencies can be flexible is to be culturally competent as families often need access to culturally, linguistically, and age-appropriate services. Families reflect cultural diversity in their values and beliefs, and in the views and expectations they have of themselves, their children, and their providers. Understanding diversity is particularly important when considering a family's perceptions of illness, health, ageing and managing changes such as family transitions, changes in family and social roles as well as losses. Staff must be knowledgeable about both mainstream perceptions and practices – and beliefs from other cultural perspectives. They must also reflect on the multicultural diversity of the families they work with.

Another aspect of integration is the concept of integrating behavioural health services into easily accessible, non-threatening places where families naturally go. This way, these families can easily access and use community based services. These services may include those that address financial, social, educational, physical health, and behavioural health needs.

Integration of services also often suggests working with a trans-disciplinary approach in a multi-disciplinary team. There is coordination of services to (a) eliminate fragmentation and duplication in service delivery; and (b) ensure all service providers have knowledge of pertinent information from all sources. To facilitate cross-programme relationships, consultation among service providers, cross-training, and family involvement can be helpful. Partnerships or collaborative arrangements beyond simple referral arrangements are a key component of integrated services. Ultimately, the goal of integrating services is to improve services as well as their availability and delivery within a coordinated, efficient system.

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