Person-centred assessment to integrate care for older people


Global consultation on integrated care for older people (ICOPE)– the path to universal health coverage

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ABSTRACT

To achieve best outcomes for older people in their health and care, we should organise care around the concerns and priorities of older people themselves. By doing this we can integrate all the assets which can contribute to healthy ageing. These assets include the strengths of the older person, family care, and support from local resources. It is best to have a standardised system for personalised assessment which can be applied to large populations of older people in primary care settings. In countries with well-developed specialist services more specialised or comprehensive assessment can be added. In this paper, we use case studies from the EasyCare project to illustrate how this approach can be implemented in poor, middle income and rich countries.

INTRODUCTION

With advancing age, people experience decline in physical and mental capacities and they accumulate non-communicable diseases and other long-term conditions leading to loss of functional ability. The effects of these changes are mitigated by the availability (or not) of personal, family, social and financial resources, the quality of the built environment and the use of assistive technologies. A comprehensive approach is needed to understand the complex factors contributing to the older adults needs and to integrate care around the specific priorities and goals of the older person in their life circumstances.

The WHO Global strategy and action plan on ageing and health provides a policy framework to ensure that societal responses to population ageing are aligned with this ambitious development agenda. The Strategy is built on the new WHO conceptualization of Healthy Ageing (1). Rather than focusing on the absence of disease, this considers Healthy Ageing from the perspective of the functional ability that enables older people to do the things they value. This ability is determined by both the intrinsic capacity of the individual and the environments they inhabit, and these should be the focus of societal action. This definition of health thus posits it as a dynamic and multifaceted process (2-3).

Consistent with this definition, healthy aging can further be conceived as reliant on processes of adaptation. For healthy aging to occur, the balance of positive assets must outweigh the presence of considerable risks at any one time. There is a long interdisciplinary tradition within the gerontology literature that underlies the role of dynamic adaptive compensation (4), resilience (5-8), or plasticity (9-10) at older ages. Despite this conceptualization of health as positive spectrum of an adaptive continuum, delivery of care in traditional models often treat the older person as a passive receiver of an intervention, without the ability to manage and mobilize resources in taking care of their health.

Personalised Care

Personalised approaches in care differ from conventional ways of care delivery in not only recognizing, but also empowering the older person and their families to participate in making decisions about their health (11).
Health and care practitioners need to develop skills to respect and ensure joint decision-making, and to undertake a holistic needs assessment that recognizes both the biopsychosocial needs and capabilities of the older person. It is important that an older person’s adaptive capability \((12,13)\), or the constellation of resources that are needed to ride out and overcome age-related declines, can be measured and mobilized. Services need to be organised to provide continuity care for the older person, across organisations and over time.

**Integrated Care**

Most care systems are better designed to deal with specific short-term needs, rather than complex and chronic health needs that arise with increasing age. Health and long-term care systems are known to operate independently, leading to inefficient usage of services and cost shifting, and ultimately to poorer outcomes. While the need for integrated care is well accepted, how to best implement and enable integrated care remains the question \((14)\).

An essential strategy to attain integrated, people-centred health services is to build strong primary care-based systems due to their outreach to the wider population of older adults in the community \((15)\). This approach involves not just multidisciplinary health professionals but a range of other formal and informal caregivers.

**Personalised Assessment**

The gold standard in assessment of older people is comprehensive geriatric assessment \((16)\). It has been defined as “a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail elderly person in order to develop a coordinated and integrated plan for treatment and long-term follow-up”.

The key challenge is to extend the principles of comprehensive geriatric assessment to non-specialist settings and resource poor health care settings \((17-19)\). Here a holistic approach to assessment is needed which can be learned, implemented and interpreted by non-specialists. This can be supplemented with more specialized information, where resources permit and more detail is needed.
A simple framework of assessment incorporates four levels (Fig. 1).

Fig. 1: Continuum of Assessment for Older People Towards Integrated Care Planning.
Personalised Care Planning

An integral part of a personalised assessment is to create a care plan, with a summary of identified problems, priorities, goals and actions. A review date needs to be set so that actions can be confirmed, outcomes recorded and further interventions planned (20-21).

Informed and valid consent must be obtained not only to respect the person’s self-determination concerning their care and treatment, but also to establish trusting relationships between the person and their caregivers. This is particularly important as information is shared with others involved in the person’s care. Data about concerns, priorities and outcomes can be extracted, subject to consent, to support research and inform the development of age-friendly policy, services and practice, focused around the priorities of older people.

Shared decision-making should underpin all care practices if the person’s autonomy is to be respected and supported. Mental capacity needs to be considered for informed decision-making. Cognitive assessments cannot be used as the sole measure of mental capacity. A mental capacity assessment of the older person should cover their ability to receive information, to retain information, to evaluate information and to communicate their wishes. If capacity is limited, someone needs to be identified to act as an advocate for the older person.

Personalised Response

Older people’s priorities for their health and care have much in common across the world; to maintain functional ability to do the things which are important to them and not be a burden to their families, but the means of responding to their priorities varies greatly because of differences in resources, technology, culture, geography, accessibility of health and social care services. Care planning should be based on understanding individuals’ concerns and take account of resources which are available locally which can be used to address their priorities for care. Assets include the strengths of the older person to manage their own care needs, support from family, neighbours and friends, voluntary, private and statutory health and care services, housing and financial resources and the availability of assistive technologies. Resources can then be matched to the priorities of the older person for support.

Case Studies

The EasyCare method for personalised assessment was created to provide a standardised, holistic and personalised assessment of older people for use in primary care. Over the last 25 years it’s use has been validated in over 30 countries (22-29). The following case studies describe how the EasyCare method could be used to transform older people’s care in poor, middle income and rich countries.

Uganda
According to the Uganda National Housing and Population Census, older persons constitute 3.7% of the entire population of 34.6 Million people (30). 53% of the older persons have no formal education while 80% of the female older persons are illiterate compared to 41% of the male (31). About 85% of the active older persons are engaged in substance crop farming with no social security, rendering them very vulnerable.
Like in most sub-Saharan African Countries, older persons in Uganda tend to play a critical role in the wellbeing of families, but traditional models of care and support for the older persons in the community appear to be weakening (32,33). Older persons are often seen as a burden and less as contributors to the well-being of the family, community and society. Older persons feel less secure than in the past and more vulnerable compared to the younger generation (34). Even though a national policy for older persons is in place is since 2009 (35), there are almost no financial resources and there is little implementing capacity and skills to address older persons’s issues in government, civil society organizations and communities.
Addressing the key challenges of ageism, lack of awareness and commitment at all levels of society, lack of knowledge and skills to engage with older persons, lack of appropriate services and limited resources requires a cost-effective approach that reveals the strength of people and communities. Unmet health needs are common among older persons and must be considered in the social, economic and cultural context of ageing. This requires actions that involve older persons in their own programs, so that they remain active in family and community life but also receive care and support when needed.

In Uganda, the EasyCare approach was implemented in conjunction with the community life competence approach. This involved a two-step process that aims to facilitate community self-reliance by encouraging older people to appreciate their strength and abilities. First, the issues and concerns identified by an EasyCare assessment are raised at a community meeting. Then an action plan is developed to facilitate a supportive environment for older people.

An NGO (Health Nest Uganda) used the EasyCare instrument for the first time in 2011 after it had been translated and validated in ten participants in Uganda by the Medical Research Council Uganda Unit/ Uganda Virus Research Institute. This was followed by a pilot study with 54 participants which demonstrated the feasibility and relevance of the EasyCare method combined with efforts to strengthen community responses and health services.

In 2011, 36 facilitators from 12 districts (approximately 12 million people in total) of Uganda were trained to use EasyCare tool and the strength based approach, and in 2012, the Government of Uganda accepted the approach as a new way of working with elderly populations and it was included a manual for training community workers on assessing issues of elderly people.

Use of the EasyCare assessment in Uganda has led to an increase in attendance at community meetings to discuss the needs of older people, the development of action plans, and the mobilization of human and financial resources to assist and support older people. Older people have been helped to maintain functional capability, loneliness has
been addressed through support groups and financial resilience strengthened through income-generating activities.

Combination of the EasyCare assessment with a strength based methodology has created a dialogue between elderly people, community members and health service providers with a strong focus on concerns being clearly identified and properly addressed. Most importantly, this unique approach has ensured that the older person's views are captured and made available to those subsequently involved in their care who may not be aware of some of the threats to the older person's health, independence and well-being.

Large-scale training of all councillors for older persons in the use of EasyCare and Community Life Competence Approach in Uganda is currently being developed.

**China**

Just like in many countries, people in China can now expect to live much longer than ever in history. Nation-wide life expectancy at birth is 76.34 years (36), and expected to reach 79 by 2030 (37). With 230 million senior citizens or the world’s largest population over the age of 60 (38), China is facing the unprecedented challenge of preparing the society for a fast-growing new “kingdom”. The number of people enjoying such longevity, as well as the diversity of their needs, require a new system to better understand and serve them.

After various guiding opinions from the State Council to accelerate the development of services, especially health services for the ageing population, in late 2016 Ministry of Human Resource and Social Security announced the piloting of long-term care insurance in 15 cities, encouraging different models to be tested. Although it is widely agreed that financing can greatly drive the growth of care services, which is already urgently needed by the over 40 million dependent or semi-dependent elderly, the current supply side calls for more innovative models of care than the previously institution-centred one.

China needs a unified, scientific way of assessing the needs and planning services for our seniors.

Founded in 2004, Pinetree Care Group has benefited a lot learning from the experience of caring for the ageing population in other countries. Knowing how some models in welfare states cannot be replicated in China, it focussed more on less resource-intensive and more efficient ways of care, i.e. the restorative care model. Moreover, to enable caregivers from various backgrounds and mobilize as many groups as possible, an algorithm was created to automatically produce the restorative care plan with inputs from a standardized need assessment and the personal goals of each individual to be cared for. By focusing on rehabilitating and maintaining the physical and mental functionalities of every person, not only has Pinetree Care helped hundreds of thousands of families see improvements in quality of life, it has also managed to change the once heavy burden of care-giving into more meaningful, uplifting career for the caregivers, effectively attracting thousands of young talents into this field.
In more and more provinces, the Pinetree model is being introduced. Many organizations are trying to build platforms linking up potentially millions of care-giving talents and tens of millions of families in need following the big success of sharing economy for cars, bikes and beauty services. However, a key challenge lies ahead: without a single tool to assess the diverse needs and allocate such “jobs” to a universally trained skilled care force, the platform simply letting service users and providers match-make themselves won’t do it.

The EasyCare method was first introduced in China through inclusion in the 2015 Chinese Longitudinal Healthy Longevity Study. In March 2016, following at a Global Coalition on Ageing Roundtable in Shanghai themed “Path to Healthy and Active Ageing – the Connection between Functional Ability and Economic Growth”, Pinetree Care decided that it would be the right time to formally introduce the EasyCare assessment and care planning tool into China.

A Train-the-Trainers training workshop was undertaken with 22 participants from Pinetree Care Group, Renmin University, Tsinghua University, Peking University, Peking Union Medical College Hospital as well as China Association for Gerontology and Geriatrics.

Trainers have started looking into our existing assessment tools with a new perspective, forming a task force to review how questions have been asked and whether customers’ personal needs and goals are always fully respected in care planning. After understanding how a local library of resources can be built to always provide locally relevant and realistically useful responses to the needs identified through the EasyCare assessment, the Trainers started to broaden their responses to identified needs and expand offerings through partnerships.

At the same time, training in the EasyCare method has been updated to include the Pinetree Care approach to restorative care, following three principles 1. Change the “default” from accepting “functional decline and loss” as a final verdict to identifying and providing interventions to the functions that can still be restored and maintained. 2. Align the goals of what matters most to the older person (and his/her family caregivers) with the priorities in their care plans. 3. Motivate the cared-for person to be part of the team.

The EasyCare method combined with the Pinetree Care model of restorative care has huge potential to promote personalised care for older people in China and to support the national policy of providing care for people to remain in their own homes for longer in a better state of health and independence.

UK

Bridlington is a deprived coastal town in the north-east of England. It has a population of 42,000 with 13% aged over 75 years. It is in the second lowest decile for deprivation nationally.

The publication of the NHS Five Year Forward View (39) suggested a different future for the traditional silo approach of primary, secondary and social care, and the
marginalization of voluntary care. This philosophy led the local health & social care providers to seek funding for the EasyCare project to assess need and deliver interventions across usual care boundaries, with the aim of keeping our population healthier and more active for longer. The EasyCare studies in Bridlington were implemented in 2015-2016.

A local telecommunications company (KCOM, Hull) identified two members of its telesales team who undertook a one day training course in Person Centred Care using the EasyCare assessment. Working full time on the project, they undertook the telephone consultations which comprised 78% of the assessments. This method of interview was found to be highly acceptable, with an average completion time of 20 minutes. Face to face interviews were conducted by 4 members of the research team and took between 30 minutes and one hour to complete. Follow-up evaluations performed 4 weeks after initial assessment averaged 6 minutes.

3359 participants over the age of 75 years were identified from the registered lists of 3 General Practices in Bridlington. Written invitations to participate were sent out and assessments were undertaken between August 2015 and January 2016. 1437 (42.8%) of consent forms were returned with a final number of 1109 (41.8%) completing both surveys and being included in the analysis. 55.6% were female, 44.4% male with an average age of 81 years. 83% lived in an urban environment.

Bodily pain was the most commonly identified problem, followed by financial worries, loneliness, memory loss and weight. 15% identified themselves as a carer and 22% were receiving care. Whereas previously, if patients identified these needs, a response would have involved medication or onward medical referral, the project signposted participants to local services appropriate for their need. A local directory of services, building on work previously undertaken by the Local Authority, facilitated such referrals. As the project proceeded, gaps in provision were identified, such as arthritis support, carers needs and rural transportation, which were addressed through investment in these services.

A directory of over 150 local links was created ensuring that each item of the assessment had at least one signposting option. 339 individuals were given such advice. 319 people were referred to low level services (health trainers, benefits advice, minor aids, fire safety, accommodation/ heating) £307,049 (349,150 Euro) in hitherto unclaimed benefits were awarded because of benefits advice; the highest award was £13,372 (15,205 Euro) being paid to one individual.

90% of participants found the assessment helpful in identifying health & care needs important to them, and which previously would not necessarily have been identified or accessed.

Older people’s independence was increased and suffering from long-term but preventable health issues was reduced. Hospital admissions were reduced, whilst care planning and community and voluntary service activity was increased.

Combination of use of the EasyCare personalised assessment method assessment and simultaneous development of a local directory of services, changed the culture of care delivery increasing the resilience and well-being of the community.
An independent evaluation by the policy group ILC-UK (40) suggests that savings of up to £3.3 billion (3.75 billion Euro) could be made between 2014 and 2030 by adopting this process nationally in the UK, through reductions in the need for long-term care.

**CONCLUSION**

Comprehensive geriatric assessment is the gold standard in specialist care for older people with complex needs relating to frailty, functional dependency and their interaction with environmental, psychological and social factors. The principles of comprehensive geriatric assessment can be extended to benefit a much wider group of older people, using simpler and personalised assessment systems.

Front-line health and care practitioners in primary care should be trained in personalised assessment methods. The assessment should focus on the concerns and priorities of the older person. Community assets should be mapped and mobilised to respond to the older person’s priorities for support. Subject to informed consent, including a mental capacity assessment where appropriate, assessment information should be shared and built up over time to create a single, shared care record, with secondary information extracted to inform research, policy and practice.

The EasyCare system of personalised assessment within an integrated care framework demonstrates a transparent method for integrating care around the priorities of the older person which can be implemented in primary care settings in poor, middle income and rich countries, and provide comparative data about concerns, priorities, resources, interventions and outcomes which can be achieved for older people.
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