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To: The Board

Through: Margot Mains

Date: 6 October 2004

Subject: Integrated Home and Community Care

Introduction & Background

At its meeting on 2 June 2004, the Board considered the integrated home and community care proposal and:

- Approved release of the public consultation document, subject to amendments identified by the Board.
- Agreed that the public consultation process will run from June 15 to July 28 and will include the joint CPHAC / DSAC forum on home and community care.
- Agreed that management reports back to DSAC in August and the Board in September with a summary of consultation responses, the consequent finalised description of the integrated home and community care service model, and an implementation plan for managing the changes.

This paper provides the report back referred to above. The Board is asked to consider and approve the draft implementation process outlined in this report. Until finalised by the Board, this paper is submitted under public excluded section as it is important that DHB staff, providers and others affected receive clear information about the agreed implementation process and timeframes. The recommendations do seek approval for public release of this paper if approved by the Board at its meeting.

This report is presented on the basis that the Board has already received a description of the proposed changes through the consultation document, and a high level business case for the approach through the supporting document. These documents were presented to the Board in June and this report therefore build on these prior documents.

Executive summary

In June 2004, C&C DHB released the proposal for the 'Integration of Home, Community, primary and Specialist Services' in C&C DHB for public consultation. The consultation document and supporting analysis is available at www.ccdhb.org.nz under public consultation, along with the summary of the consultation responses.

Taken as a whole the proposal will deliver an important strategic aim for C&C DHB as per the District Strategic and Annual plans, namely supporting the integration of care across the continuum, improving access to services and reducing disparities. Over-all, the response to the proposal was very positive with respondents agreeing the model would improve services and that the approach will achieve the objectives. As a result of the consultation, some key changes to the original model have been made including:

- For the first two years the majority of Care Managers will be employed by the Care Coordination Centre, rather than PHOs.
- Care Managers will be ACC contracted assessors
- The minimum age for entry to the service will be reduced from 18 to 16 years

To ensure a measured approach, this paper includes a draft implementation plan for the proposal that broadly covers three stages. These are:

- A specification phase where services are specified – this will span from October 2004 to January 2004
- An establishment phase where new integrated processes are designed and tested. This will last from February 2005 to September 2005
- A roll out phase where services are commissioned and put into operation. This will last from September 2005 to February 2006

Through implementing the proposed model we anticipate that C&C DHB will be able to control, at a conservative estimate, up to 5% of residential care admissions and up to 5% of acute hospital admissions per year. These are the main cost drivers in terms of health expenditure* in C&C DHB and pose large clinical and financial risks to C&C DHB if their growth remains unchecked.

This proposal largely involves a re-distribution of current expenditure and resources, however, there are additional up front costs of approximately \$70,000 one off and \$400,000 per year ongoing, previously budgeted in our new initiatives pool for 2004/05. The Board is asked to note that the financial implications identified in this paper are estimates only and further financial analysis will be undertaken as implementation progresses. This paper seeks Board approval for the implementation plan and consequent financial and service changes included within this paper and approval for public release following consultation with affected staff and their representatives.

* Expenditure does not necessarily equate to actual costs, due to fixed costs associated with HHS service provision.

Consultation Responses

The attached Report on Submissions has been prepared by an independent party from written submissions, attendance at consultation meetings, and notes from the CPHAC / DSAC forum on 23 June 2004. It indicates that, over-all, the response to the proposal was very positive with respondents agreeing the model would improve services and that the approach will achieve the objectives.

Many questions raised in consultation related to implementation and service development, in particular where Care Managers should be based. As a new role many issues were raised which related to how standards of service would be maintained if the Care Managers are based in Primary Health Organisations (PHOs). Issues related to standards of service include care manager:

- Training
- Budget management
- Support from other staff
- Supervision and peer review
- Interface with other funding streams, particularly ACC and mental health.

Different views on how the model should be implemented were expressed, although a staged implementation process was generally favoured.

The report on submissions is available at www.ccdhb.org.nz under public consultation along with the original consultation document.

Changes to the Service Model

The consultation process therefore largely confirmed the advisability of the proposed model and approach. However, three key changes have been made to the proposed model as a result of the consultation feedback and more detailed analysis completed by Planning and Funding in the interim period. These changes are:

- For the first two years the majority of Care Managers will be employed by the Care Coordination Centre, rather than PHOs.
- Care Managers will be ACC contracted assessors.
- The minimum age for entry to the service will be reduced from 18 to 16 years.

The first change has been made as a result of the feedback noted above which stated that it is crucial for the Care Managers to receive appropriate training, supervision, and development. In the first instance this can be more easily and effectively achieved through one main provider which has the critical mass to ensure this workforce development occurs. The Care Coordination Centre will therefore be contracted on this

basis to deliver care management services to specified quality and workforce standards. If practicable there will be a limited number of Care Managers employed by PHOs and the hospital on a trial basis, however, the Care Coordination Centre will be the majority employer and will provide workforce development across all Care Managers in the district including any employed in other settings.

Care Managers employed by the Care Coordination Centre will still be expected to have strong linkages and integration of care with both primary and secondary care based health professionals. To facilitate this, Care Managers will have a nominal 'catchment population' that relates to specific PHOs and primary care practitioners. They will be expected to build up strong working relationships with both primary/PHO and secondary/multi-disciplinary clinicians, and spending time in both settings will be part of their orientation and professional development.

After two years of full operation the Care Manager workforce will be better defined and developed, and PHO establishment fully bedded in. At this stage the employment of Care Managers will be reviewed, with a view to devolving this employment relationship to PHOs and some to specialist services. Care Managers will continue to be supported by a district wide workforce development and supervision plan.

Following discussions with ACC, and feedback from consumers about the importance of integrating ACC funding into the model as much as possible, a requirement that Care Managers are able to be contracted ACC assessors will be introduced. This will effectively mean that one Care Manager will be able to complete the health, support needs, and ACC assessments necessary for their clients which will reduce duplication and fragmentation of assessment and care.

Likewise, feedback from consumers has emphasised the importance of ensuring that those aged between 16 and 18 years do not fall into a service gap. The minimum age has therefore been lowered to align with the age cut-offs for access to child health services (0 – 16 years).

There will also need to be clear processes to support consumer's right of review of their care plan and clear systems to manage complaints.

Development and Managing Change

Considerable changes across many services will be required to implement this integrated system of care within C&C DHB. The following key principles will therefore guide this implementation:

- The outcome of the development must improve the integration of care across services and move away from the current fragmented approach. Where indicated, developments will build on what is working well already within the DHB.
- Service delivery will be maintained during the process

- Developments will disrupt current service delivery as little as possible
- All developments will occur in a controlled fashion
- All developments will be clearly communicated in a timely manner
- The best provider or mix of providers will deliver services in a flexible manner
- The C&C DHB workforce is valuable to C&C DHB and maintaining their skills and knowledge within the district is important to continually improve services
- Standard change management procedures apply, as there are likely to be changes in the configurations/roles of some positions. This includes ongoing consultation and communication with affected staff as changes occur (see appendix 1)
- Best efforts will be made to avoid mistakes, however when they occur they will be seen as opportunities from which to learn

To ensure a measured approach, implementation will occur over three broad phases. These are:

- A specification phase where services are specified – this will span from October 2004 to January 2004
- An establishment phase where new integrated processes are designed and tested. This will last from February 2005 to September 2005.
- A roll out phase where services are commissioned and put into operation. This will last from September 2005 to February 2006

Essentially there are five major deliverables, they are:

- Care Manager service
- Care Coordination centre
- Specialist teams - stroke, specialist services for older people
- Developing more flexible home and community services
- Development of a single assessment process supported by the roll out of the InterRAI MDS suite of tools

Overall, we anticipate that the integrated system will be largely implemented by February 2006. This will however only be the start of a longer service development process which ensures ongoing quality and process improvement over time.

To ensure that developments occur in a controlled manner a project management methodology is being used and a DHB programme steering group of senior managers and advisors including Margot Mains (Chair) has been formed to guide the implementation and management of the changes at an operational level. The full group is listed in the table below.

NAME	POSITION	PERSPECTIVE
Margot Mains	CEO C&C DHB	C&C DHB
Meng Cheong	HHS Chief Operating officer	Hospital and Health provider arm
Win Bennett	Director Planning and Funding	Service Planning and Funding
Riki Nia Nia	Director Maori Health Development	Services for Maori
Lee Pearce	Manager Pacific Health	Services for Pacific
Benedict Hefford	Manager Aged Care & Disability	Service Planning and Funding
Carey Virtue	Business Manager Clinical Support Services	Hospital and Health provider arm
Robin Nicole	HHS change management advisor	Human Resources
Julia Carr	Senior Portfolio Manager Primary and Community Care	Service Planning and Funding
Nigel Millar	Chief Medical Officer and Geriatrician Canterbury DHB	External clinical expertise

This group is a high level internal management group and it is important to note that service developments will occur with input from and reference to consumers, providers, health professionals and advisory groups that currently exist. Specific service development groups will also be formed as required to guide implementation of specific parts of the programme.

Project teams will be formed to implement various aspects of the programme. Implementation will proceed on an 'approval to proceed' basis as directed by the programme steering group in relation to ongoing monitoring and evaluation of:

- Continued viability of the business plan.
- Risks associated with implementation
- Project timeframes

Core to implementation will be developing the processes that will need to be in place across all aspects of the model.

MONITORING AND EVALUATION

As each new service comes 'on stream', each service will have various quality reporting requirements to report back to the DHB on a regular basis to ensure ongoing monitoring and evaluation. For example the Stroke service may have reporting requirements such as:

- Proportion of stroke patients admitted to a stroke area identified for stroke patients
- Time from admission to hospital till admission to stroke area
- Time of brain imaging completed at admission
- Proportion of Neurovascular out-patient referrals seen within 14 days
- Discharge location for people who have had stroke (percentage returning home versus entering residential care).

There will be a formal external evaluation of the programme when the model as a whole has been in operation for two years. This will cover progress towards achieving the vision and objectives defined for the programme. The programme will be evaluated through indicators such as:

- Review of trends of service use and access across acute services, out-patient services, community services and residential care compared with the start of the programme. The baseline for this analysis has already been completed through the supporting document.
- Health outcome indicators relating to morbidity and mortality
- Trend analysis in terms of costs/use of residential care and acute unplanned hospital costs compared to home care costs
- Trend changes from the 2002 C&C DHB Health Needs Assessment
- Consumer and provider satisfaction surveys
- Interviews with key stakeholders involved in developing the model.

FINANCIAL RISKS, ASSUMPTIONS & IMPLICATIONS

Current C&C DHB Risks

The main cost drivers in terms of health expenditure are avoidable acute hospital admissions and admission to aged residential care. These pose large clinical and financial risks to C&C DHB if their growth remains unchecked.

Asset testing for residential care is also being substantially reduced from July 2005, further increasing financial risk to the DHB in this area.

Our aging population, and those with chronic diseases eg chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF), has the potential to increase health and social care costs on a system that is already under great strain.

The C&C DHB health needs assessment shows that up to 30% of acute hospital admissions are preventable. The expenditure on preventable hospital admissions for C&CDHB for 2004/05 is likely to be approximately **\$19, 628 000***. Approximately a third of these admissions are related to people over the age of 50. The annual growth rate of acute expenditure is approximately 5%.

C&CDHB currently funds approximately **\$26,000,000** per annum on residential care. The annual growth rate of expenditure in residential care in C&C DHB is approximately 5%.

Assumptions

The following figures noted in this paper are estimates only as they are based on modelling from:

- Historical data from FY 2002/03
- 2004/2005 prices (revenue as opposed to cost)
- International evidence and examples
- Comparisons with similar services (for example in the case of the Care Coordination Service comparisons have been made with other similar services in New Zealand and abroad).

Thus further financial analysis will be undertaken as implementation progresses and each component service of the new model is specified and costed. The Programme Steering Group referred to above will monitor financial implications as implementation progresses.

Analysis and international evidence shows that different aspects of the model can have high impacts on acute admissions and admission to residential care. For example, specialist Older Persons teams, Care Management and the Interrai set of tools have been shown to reduce acute admissions and admissions to residential care by up to 20-25%. (Please see 'Integrated Home & Community Care Supporting Document v 1.2', (available on www.ccdhb.org.nz in the public consultation section).

We anticipate that this model will lead to an improvement of health outcomes for the C&C DHB population, more people being able to live at home for longer and better uptake of services by Maori, Pacific and those on low income.

Implementing the new service model involves both (one-off) establishment and (ongoing) operation costs of the multi-disciplinary teams, care managers, and Care Coordination Centre. Meeting these costs is largely dependent on a re-distribution of current expenditure and resources rather than additional funding, however, there are additional up front costs of approximately \$70,000 one off and \$400,000 per year ongoing which have been budgeted in our new initiatives pool.

* Expenditure does not necessarily equate to actual costs, due to fixed costs associated with HHS service provision.

Care Management Service

The Care Manager workforce will be developed over time. The total number will be approximately 20 FTEs for the district. This number based on several models:

- The Coordinated Services for Elderly (COSE) workers in Canterbury work on a one FTE per 3000 population. Taking the 50+ age group in C&C DHB, who use most home and community services this equates to about 20 FTEs
- Similar roles in Canadian Community Care Access Centres (CCACs) at any one point show active 'caseloads' of between 120 – 150
- Benchmark studies in the USA show that average 'caseloads' for similar roles are between 50 – 100.

The key component of the Care Manager service is assessment and care planning rather than case management and coordination, thus 'caseloads' is not necessarily the best terminology. The number of assessments a Care Manager can complete and monitor in a year is the important statistic. With a figure of 20 FTEs, this will allow for about 4800 assessments and care plans to be undertaken each year within the district.

Care Coordination Service

The Care Coordination Service will be developed through an expression of interest process. The total number of staff will be approximately 15 for the district and is based on requiring 2 clinical screeners, 6 service coordinators, 4 low needs assessors, 1 system administrator and 2 administration staff.

This is based on the current Needs Assessment and Coordination Service staffing levels, the current one-point entry staffing levels and comparison with other similar services. For example, a Canterbury coordination centre that currently manages a subset of the services that the Care Coordination Centre will organise, processes between 350-450 referrals a week and has one clinical screener and 4 service coordinators.

The Specialist Services (Stroke, Older Persons and Rehabilitation)

It is important to note that the revenue lines for these stated in the tables below acknowledge the flexible use of those funds and associated staff across services. For example, it is acknowledged that some of the staff involved in the stroke service will also be involved in the older persons service, Internal Medicine and so forth. Therefore implementation is more concerned with using current funding and staff differently.

The stroke service will be funded to approximately \$2.4 million This figure is based on the current funding associated with stroke that has been identified within internal medicine, calculated through 2002/2003 case weight discharges (CWD) and 2004/2005 prices, this is approximately \$2million. The additional \$0.4 million represents the sharing of additional allied health staff across other services eg across Internal Medicine, Older Persons Service and Rehabilitation.

The Older Persons service will be funded to approximately \$8.3 million. This figure is based on the current funding associated with frail elderly that has been identified within internal medicine, calculated through 2002/2003 CWD and 2004/2005 prices, which is approximately \$1.8 million. The additional \$6.5 million is current ATR funding for the 65+ age group, noting that staff in this service will also operate across the Stroke service.

Home and Community Care Packages

Home and community care packages will be funded to approximately \$15 million. This figure is based on current age related Disability Support Service and Personal Health funding for home and community nursing and support

Linked in with this will be \$2 million from Mental Health Support Service funding that is associated with the 'Graduate' population, this relates mainly to supported accommodation. 'The term 'graduates' is used to describe people aged 65 years and above, with an enduring psychiatric illness who have graduated to elderly status and are currently living in the community.

The following tables show approximate current funding for a number of services and the estimated new budgets once implementation is complete:

Table 1: Current operating budgets for relevant services

FUNDING	SERVICE	BUDGET/ EXPENDITURE
DHB – DSS	Geriatric AT&R – In patient	\$3 million
DHB – DSS	Geriatric AT&R – Community & Outpatients	\$3.7 million
DHB – DSS	Geriatric AT&R - Mental Health Services for Elderly	\$2 million
MoH – DSS & ACC	Non-Geriatric Rehabilitation	\$4 million
DHB – PH	Community Health Services (Home nursing, home support, community allied health)	\$8 million
DHB – MH	Mental Health Support Services for Older People	\$2 million
DHB – PH	Inpatient Treatment Costs for Stoke (int. medicine)	\$2 million
DHB – PH	Inpatient Treatment Costs for Frail Elderly (int. medicine)	\$1.8 million
DHB – DSS	Needs Assessment / Service Coordination for Older People (Capital Support)	\$1 million
DHB – DSS	Aged Residential Care	\$26 million
DHB – DSS	Home/Carer Support for Older People	\$7 million
	Total	\$60.5 million pa

Table 2: New operating budgets for relevant services in the integrated model

FUNDING	SERVICE	BUDGET/ EXPENDITURE
DHB	Care Coordination Centre	\$1.5 million
DHB	Care Managers(20 FTEs)	\$1.7 million
DHB	Older Persons Service	\$8.3 million
MoH – DSS & ACC	Non-Geriatric Rehabilitation	\$4 million
DHB	Stroke Service	\$2.4 million
DHB	Home and Community Care Packages (nursing, home support, community allied health, carer support)	\$15 million
DHB	Mental Health Support Services for Older People	\$2 million
DHB	Aged Residential Care	\$26 million
	Total	\$60.9 million pa

Potential Human Resource Implications

A number of human resource issues have been and will continue to be carefully managed through this change programme. The major implications relate to the potential change in role and/or employer for some Capital Support, AT&R, Therapies and Community Health staff who may transition to positions in the new services. The potentially affected HHS staff by service are shown in the table below.

Table 3: Potentially affected HHS staff

ALL SERVICES	FTE (APPROXIMATE)
Service/team leaders	19
Medical/AHP Advisors/ Nurse Consultants	13
Therapies	46
CHS	74
ATR	34
Psycho-geriatric Team	18
Capital Support	27
Total	231

Implementation Phases

The proposed implementation approach is based on a broad three stage roll-out, with the specification phase being completed shortly, followed by an establishment phase and full roll-out occurring towards the end of next year. This point will be the start, rather than end, of ongoing service development to improve processes and quality over time. It should be noted that some phases will overlap depending on individual projects.

Specification phase – October 2004 to January 2005

Each part of the integrated model will undergo a specification stage. This will consist of defining:

- What the services are
- What services are meant to achieve
- How services will be purchased and contracted
- Monitoring and reporting

More detailed financial analysis will also occur during this period to fully define the funding for each service.

Establishment phase - February 2005 to August 2005.

This phase will see the establishment of some services which will be monitored and evaluated as they come on stream. As part of this phase, a first wave of Care Managers will be established. The aim of the first wave will be to:

- Test and further define a core set of working processes for the role, for example with ACC assessment and funding included
- Further define and make recommendations for the development of the role in the future.

In addition, this phase will include initial development of the use of the Inter RAI MDS suite of tools to initiate the development of the single assessment process. The principle here will be to:

- Establish a group of clinicians within different services who are familiar with the tool
- Map out current assessment processes
- Establish how the tool will be used in conjunction with current assessment and care planning processes
- Make recommendations for roll out across different services

We anticipate that this will be undertaken along with Canterbury District Health Board, Hutt Valley District Health Board and Waikato District Health Board to ensure that

opportunities for joint development can be maximised. The software will be provided on an evaluation basis only by 'Assessment and Intelligence Systems' of Canada. This product is only provided for pilots or research and will not be used for any 'live' roll out in the future.

In this phase the links and processes within and between each part of the model will need to be designed and tested. This will be completed by service development teams and will incorporate, for example, processes relating to:

- Referral
- One point of entry
- Screening and triage
- Assessment and care planning
- Care plan monitoring
- Liaison
- Service coordination
- Indicative and actual budget monitoring/invoicing

These processes will be defined across:

- Hospital & Health Services (HHS)
- Primary Health Organisations (PHOs)
- Community providers
- ACC
- Care Managers
- Care Coordination centre

Some of these processes will need to be interim measures only while the system develops, for example the processes for referrals to Care Managers and coordination of their care plans prior to the Care Coordination centre being operational.

Roll Out phase – August 2005 to January/February 2006.

Care Managers

An additional 10 FTE Care Managers will be established during this period to be employed by the care coordination centre.

Specialist Services

The specialised services, (Older Persons Service, Stroke and Rehabilitation) will be three integrated teams developed from current Hospital and Health Services (HHS) structures. In the New Regional Hospital all the in-patient components of these services will be based at Kenepuru, except some flexible acute stroke beds which will be based in a geographically defined area at the Wellington site.

Following the establishment of the stroke service, this team will develop stroke pathways across primary and secondary care under direction from a lead clinician.

Care Coordination Centre

The Care Coordination Centre will be established through a registration of interest process (ROI), from organisations who have expertise in providing this service, including the HHS and current providers in other parts of New Zealand. The C&C DHB Board will receive a report following this ROI on options for establishment of the CCC. Throughout this process, the current one point entry and service coordination services will stay in operation and will continue until the Care Coordination centre has been in operation for approximately six weeks.

Home and Community Services

Requests for proposals for provision of home and community nursing, support, and some allied health care will be issued to help define the best configuration of these services in future. Provision of different types and packages of care will be defined and providers selected on the basis of quality, effectiveness, and efficiency in the context of the integrated model.

An internal transfer of planning and funding/contracting responsibility for mental health support services (for example, supported accommodation) and service coordination for older people with enduring mental illness will be completed within the DHB. This will allow Care Managers to organise service delivery for this 'graduate' group of clients in an integrated way with other older people's services.

Summary

The following table shows a broad summary of some of the key milestones. Please note that this is a broad outline and will be subject to change as and when circumstances change during the programme timeframe. The C&C DHB Board is asked to approve the first two phases ie until August 2005.

	TIMEFRAME	KEY OUTPUTS
Phase one: Specification	October 2004	Service specifications finalised
	November 2004	Funding & purchasing for specialised services defined
		Training for core users in Inter RAI MDS completed, use of Inter RAI started in one area
		ROI for Care Coordination Centre (CCC) issued
Phase two: Establishment	February	Inter RAI pilot software deployed and tested
		ROI for Care Coordination centre evaluated
		Interim referral screening, service coordination processes defined for first wave of care managers
	March 2005	Stroke, Older Persons + Rehabilitation services configuration plan completed
		Report to Board on options for implementing the roll out phase, including establishment of the CCC
	April 2005	First wave of Care Managers employed and start using Inter RAI tools
		Integrated processes defined by service development group
	May 2005	Requests for proposals for Home and Community Care packages issued
	July 2005	Stroke, Older Persons + Rehabilitation services configured
	Transfer of Mental Health support services funding for older people (graduates)	
Phase three: Roll out	August	Contract for Care Coordination Centre awarded
	September/October 2005	Care Coordination 'go live' second wave of care managers employed
		Roll out of integration processes
	November 2005	Contracts for Home and Community Care packages issued

Overall the final model will be as per the tables below. For each component, one or two benefits have been described, where financial benefits are noted these are based on 2004/05 costs unless stated otherwise.

CARE MANAGER SERVICE	
Main Functions	Early pro-active assessment and care planning
Projected FTEs	Approximately 20
Volumes	50 – 70 active caseload approx 1 role per 3000 head of population Approximately 240 assessments per year per Care Manager
Funding	Approx \$1.7million pa
Health and financial benefits	Admissions to hospital prevented eg Congestive Heart failure approx: \$2,931 per admission Chronic obstructive pulmonary disease approx \$3,481 per admission* Reduced incidence of specific conditions eg fractured neck of femur (\$9,000 per admission)
Example indicators	Waiting times for assessment Access to service by ethnicity/socio-economic groups Consumer satisfaction Changes in functional ability/levels of risk while under care manager Identification of consumers at risk of falls while under care manager Identification of consumers with rehab potential while under Care Manager Number of unplanned admissions while under Care Manager service Rate of admission to aged residential facilities while under Care Manager service Clinical indicators eg number of fractured neck of femurs/incidence of stroke while under care manager service

* note FY 02/03 costs

CARE COORDINATION SERVICE	
Main Functions	Central district wide coordination of care
Funding	Approximately \$1.5 million pa
Volumes	Approximately 400 referrals per week
Projected FTEs	Approximately 15
Benefits	Reduced duplication of administration Central access to information Timely processes for referrals and service coordination
Example indicators	Consumer/provider satisfaction with care coordination and access to information Access to services by ethnicity/socio-economic groups Waiting times for delivery of service

SPECIALIST HEALTH SERVICE FOR OLDER PEOPLE	
Main functions	Inpatient and Community assessment, treatment and rehabilitation of older people with established complex/multiple needs
Funding	Approx \$8.3 million pa.
Projected FTEs	Approx 35
Health and financial benefits	1 less admission to residential care per year = \$33,000* saving pa (fully subsidised rest home level) Reduced disability levels in this group of consumers
Example indicators	Access to services by ethnicity/socio-economic groups Consumer satisfaction Waiting time for service Length of stay and re-admission rates for in-patients Changes in functional ability while under service Changes in level of risk while under service Changes in polypharmacy by consumers Discharge location from service, eg rest home versus home

*note based on 2002/2003 funding

STROKE SERVICE: ACUTE + SECONDARY PREVENTION	
Main functions	Management of people who have had stroke
Funding	Approximately \$2.3 million pa
Health and financial Benefits	1 stroke prevented = \$50,000 saving Reduced numbers of stroke Reduced mortality rate for those who have had stroke 1 less admission to residential care per year = \$33,000 saving pa (fully subsidised rest home level)
Example indicators	<p>Access to services by ethnicity/socio-economic groups</p> <p>Consumer satisfaction</p> <p>Waiting time for service</p> <p>Lead clinician employed</p> <p>The proportion of patients spending more than 50% of stay in stroke service</p> <p>Screening for swallowing disorders within the first 24 hours of stroke.</p> <p>Brain scan within 24 hours of stroke</p> <p>Patient commenced aspirin by 48 hours after stroke.</p> <p>Physiotherapy assessment within first 72 hours.</p> <p>Assessment by an occupational therapist within seven days.</p> <p>Patient was weighed at least once during admission.</p> <p>Patient's mood was assessed during admission.</p> <p>The patient was on antithrombotic therapy by the time of discharge.</p> <p>Rehabilitation goals agreed by the multidisciplinary team.</p> <p>A home visit is performed before discharge for applicable patients.</p> <p>Length of stay and readmission rates for in-patients</p> <p>Discharge location from service, eg rest home versus home</p> <p>Proportion of Neurovascular out-patient referrals seen within 14 days</p> <p>Rate of secondary strokes</p>

HOME AND COMMUNITY CARE SERVICES	
Main functions	Provision of home and community based nursing, home support, and allied health care packages
Funding	Approximately \$14 million pa
Projected FTEs	300 plus
Health and financial Benefits	Ability to remain at home Safe and effective discharge services Maintenance and rehabilitation in the community
Example indicators	Access to services by ethnicity/socio-economic groups Waiting times for service Consumer satisfaction Rate of entry to aged residential care Unplanned admissions while receiving care packages Changes in type of care packages delivered

Risk Management

Taken as a whole this programme will deliver an important strategic aim for C&C DHB as per the District Strategic and Annual plans, namely supporting the integration of care across the continuum. Continuing with the current way that services are funded and organised will likely result in:

- Increased acute in-patient and residential care costs in future
- Sub-optimal health outcomes for the funding provided
- Continued consumer and provider dissatisfaction with services
- Workforce issues through staff retention as provision of services becomes increasingly difficult
- Risk of medico-legal action if care remains poorly integrated and unresponsive to need

as care will become increasingly fragmented and more consumers will fall between services and funding streams.

The following table gives an overview of the major risks associated with this programme and their associated management strategies. Risks to the programme will be monitored on a monthly basis by the programme steering group.

Risk Description		Current Controls/ Treatment	Additional controls required/Key actions still to complete	Residual Risk
Type of Risk	Description of Risk			
Financial risk	Failure of C&CDHB to release sustainable funding/resources for programme	Identification of expenditure required prior to programme start Communication of plan, staff and time required from CCDHB at earliest opportunity	Analysis of expenditure as programme is implemented Monitoring of expenditure against trends as programme is implemented Staff required for programme identified prior to work starting and their time ring fenced	202
Clinical risk	Failure of CCDHB to successfully implement integrated services and care delivery will result in poor health outcomes	The programme has a supporting management structure capable of ensuring changes to service delivery occurs Thorough definition of service specifications and development plans occurs Current services will remain 'open' through any transition period with new providers.	Service development group of clinical staff and service managers to lead development of integrated processes to be formed Incremental approach to signing off practice changes On going training and communication of new processes to relevant staff Monitoring and evaluation of services as they are implemented	135
Service delivery risk	Workforce levels decrease due to poorly integrated care or uncertainty of future service configurations	Monthly monitoring of staff vacancies. Early involvement of change/HR advisors/staff representatives during programme. Clear indications made in a timely manner to staff of service configurations	The ongoing communication plan ensures all staff are up to date with changes in services and processes Ongoing involvement of change/HR advisors/staff representatives during programme.	112

Risk Description		Current Controls/ Treatment	Additional controls required/Key actions still to complete	Residual Risk
Type of Risk	Description of Risk			
Service delivery and public/political	Loss of confidence in programme by consumers/public due to potential for service disruption during transition phases	<p>Schedule any major transitions after the Care Coordination centre has been in operation (this will play a role in managing that process)</p> <p>Clear and timely communication of any transitions to relevant stakeholders</p> <p>Current services remain 'open' through any transition period with new providers.</p> <p>Standards for 'transfer of care' defined if transition of services required</p>	<p>ROI processes completed with adequate lead in time</p> <p>Transition working defined within new contracts to allow transfer of care and staff if required</p>	112

Communication Planning

Throughout the process it will be important to keep affected staff and key stakeholders up to date with developments regarding:

- Work currently in progress
- Work to be completed
- New services coming 'on stream'.

Ongoing Communication For Affected HHS Staff

There will be a rolling programme of 'drop in sessions' for affected HHS staff occurring every 8 weeks throughout the duration of the projects. These will be mainly for staff to have a chance to discuss any issues or progress of the programme.

Sufficient flexibility will be allowed to enable targeted communications to this group of staff and their unions.

Ongoing Communication For All Staff

Updates will be provided as required through a mixture of channels, including (but not limited to):

- Margot's Update
- Chief Operating Officer's update (HHS)
- Capital & Coast (DHB newsletter)
- Handover
- 'ALL CCDHB' email updates
- Union contacts

Ongoing Communication For Primary Care and NGO Providers

Updates will be sent out to primary care providers through a mixture of channels, including (but not limited to):

- Primary Importance newsletter
- Email networks
- DHB newsletters

Regular updates with FAQs will be sent out to NGOs through mail outs.

Ongoing Communication For DHB Board and Sub Board Committees

Updates to the board and sub board committees will be via the CEOs report.

Communication Plans Prior to Launch of New Services during the programme

Each new service or change in services will have a communication strategy to 'advertise' the change.

For example, if the care coordination centre is scheduled to start business:

- The target audience will be identified
- Mail outs will be prepared
- Relevant newsletter/media articles will be prepared
- Short Presentations about the service its key features and how to access it will be prepared and venues booked to present to key audiences.

'Advertising' new services will occur for a minimum of two weeks prior to launch.

Conclusion

Consultation has reinforced the messages received from the community about the need for changes to our current service delivery arrangements. It has also given us a number of ideas about better ways of doing things and how to get there.

A comprehensive project management framework has been wrapped around the integrated home and community care programme. Despite this, difficulties will occur as we step into implementation and that is why having the new services up and running will only be the first stage of the service development process which will require ongoing staff involvement, monitoring, evaluation, and improvement.

Recommendations

The Board:

1. **Noted** that on 2 June 2004 the Board agreed that management reports back to DSAC in August and the Board in September with a summary of consultation responses, the consequent finalised description of the integrated home and community care service model, and an implementation plan for managing the changes.
2. **Noted** the attached Report on Submissions, which has been prepared by an independent party and indicates that, over-all, the response to the proposal has been very positive.
3. **Noted** that as a result of feedback from consultation three key changes have been made to the proposed model:
 - In the first instance the majority of Care Managers will be employed by the Care Coordination Centre, rather than PHOs.
 - Care Managers will be ACC contracted assessors.
 - The minimum age for entry to the service will be reduced from 18 to 16 years.
4. **Noted** that implementing the new service model largely involves a re-distribution of current expenditure and resources rather than additional funding, however, there are additional up front costs of approximately \$70,000 one off and \$400,000 per year ongoing, which have been budgeted in our new initiatives pool for 2004/05.
5. **Noted** that the financial implications identified in this report are estimates only and further financial analysis will be undertaken as implementation progresses and each component service of the new model is specified and costed.
6. **Delegated** to the CEO financial decisions necessary to implement the new services provided they are within the financial parameters of our current District Annual Plan.
7. **Approved** the implementation plan for the next two implementation phases of specification and establishment, which have been considered and recommended by the Disability Support Advisory Committee.
8. **Approved** publication of the implementation plan, including posting it to C&C DHB's website, following consultation with affected staff and their representatives and more explicit communication with service users and families/whanau, local communities and the Strategic Communications Committee.
9. **Note** that management will work with FRAC about the evaluation criteria and future peer review.
10. **Noted** that disparities will be addressed as a priority in the development of the programme.
11. **Asked** the CEO to report back to the Board with recommendations for the roll out phase, including establishment of the Care Coordination Centre once the ROI for the Centre has been completed.

Approved for release:

BENEDICT HEFFORD

Manager Aged care & Disability
Capital & Coast District Health Board

MARGOT MAINS

Chief Executive Officer
Capital & Coast District Health Board

Appendix 1

CHANGE MANAGEMENT – HUMAN RESOURCES PROTOCOLS

Key Principles

Staff and unions must be advised prior to a review commencing (Good Faith)
Staff and unions must be involved in a meaningful, genuine consultation process
The Human Resources Department must be involved as soon as the change has been defined and throughout the change process
Staff will be offered EAP type support, and be encouraged to use this, throughout the change process
Staff are entitled to have their union representative or support person present at any meeting they have with management
There will be regular, clear and meaningful communication with staff, unions and the EAP provider is to minimise confusion and ensure transparency:
The fundamental reasons for the change outlined in the proposal should be consistently reinforced throughout the process
Key messages should be communicated clearly and reinforced through multiple channels
Change will be well planned and communicated
Implementation will be well managed and communicated

Define the Change

The reasons for the change – what outcomes are required?
The kind of change, eg systems, processes, structures?
Who is likely to be affected, and in what way?
Will this be a project – or will a proposal be put for consultation?
Who will manage the process?

Prior to Communicating the Project/ Plan for Change

Scope the change
Draw up a provisional timeframe
Develop a communications plan (who, how, where, what information)
Identify resources – how is the project going to be done
Be prepared to answer questions
Identify risks and plan for contingencies

Prior to taking out a Proposal for Consultation (Refer to attached template)

Identify whether, if the proposal were to be implemented, any positions would be affected – significantly or otherwise

Advise the unions of the proposal and possible outcomes

Personally advise those staff whose positions would be significantly affected *prior* to the release of the proposal (on the same day as the proposal is presented, if possible)

Provide written advice to all staff whose positions would be affected, but not “significantly”, eg a change in reporting line (provided at the meeting where the proposal is presented)

Ensure the EAP support people are invited to the meetings where the proposal is presented – and are offered the opportunity to introduce themselves to staff

Presentation of the Proposal

It is important to include:

The reasons for the change

How staff will be involved, and when

The rights of staff in the process

The HR processes

The timelines – when will the change impact on the staff

Consultation

The Nurses and Midwives MECA provides a useful definition of “consultation”:

“Consultation involves the statement of a proposal not yet finally decided upon, listening to what others have to say, considering their responses and then deciding what will be done. Consultation clearly requires more than mere prior notification.

The requirement for consultation should not be treated perfunctorily or as a mere formality. The person(s) to be consulted must be given sufficient opportunity to express their view or to point to difficulties or problems.

If changes are proposed and such changes need to be preceded by consultation, the changes must not be made until after the necessary consultation has taken place. Both parties should keep open minds during consultation and be ready to change. Sufficiently precise information must be given to enable the person(s) being consulted to state a view, together with a reasonable opportunity to do so – either orally or in writing.

Consultation requires neither agreement nor consensus, but the parties accept that consensus is a desirable outcome.

The process of consultation for the management of change shall be as follows:

- The initiative being consulted about should be presented by the employer as a “proposal” or “proposed intention or plan” which has not yet been finalised.
- Sufficient information must be provided by the employer to enable the party/ parties consulted to develop an informed response.
- Sufficient time must be allowed for the consulted [party/ parties to assess the information and make such response, subject to the overall time constraints within which a decision needs to be made.
- Genuine consideration must be given by the employer to the matters raised in the response.

- The final decision shall be the responsibility of the employer.”

The consultation process needs to be clearly defined, including:

Who the submissions go to

What will happen to the submissions (eg be summarised into a report)

Guarantee of confidentiality, unless otherwise agreed

Timeframe

Feedback from staff can be obtained through:

Written submissions (e-mail or hard copy), individual or group

Oral submissions, individual or group

Focus groups

Submissions (unless anonymous) should be acknowledged.

A summary of submissions should accompany the final decision, and justification of the final decision should address key submission themes.

Implementation Plan

Prior to releasing the final decision, a detailed implementation plan should be prepared, including:

Process for release of final decision (see below)

Method of appointing to new positions (eg expressions of interest)

Managing redeployments/ retraining/ orientation, etc

Timeframe

Release of Final Decision

Identify the positions that will be affected – significantly or otherwise

Advise the unions of the final decision and outcomes

Personally advise those staff whose positions will be significantly affected *prior* to the release of the final decision (on the same day as the final decision is presented, if possible); provide written confirmation (content will depend on individual circumstances and employment agreement provisions – HR will advise)

Provide written advice to all staff whose positions are affected, but not “significantly”, eg a change in reporting line (provided following the meeting where the final decision is presented)

Ensure the EAP support people are invited to the meetings where the final decision is presented