



Capital & Coast

District Health Board

ŪPOKO KI TE URU HAUORA

**PROPOSAL FOR THE INTEGRATION OF HOME,
COMMUNITY, PRIMARY AND SPECIALIST
SERVICES IN CAPITAL & COAST DISTRICT**

▪ **CONSULTATION DOCUMENT**

**Improving services for older people, adults with chronic illness and others with a short
term need**

JUNE 2004

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INTRODUCTION

Our district requires a new approach to integrating home, community, primary and specialist services. We need to change the way we do things so that the care we give is based on peoples' needs and not the service that they 'fit into', as happens now. We want to ensure that people get help before problems occur and make sure that the care they get is coordinated properly.

WHAT ARE WE PROPOSING?

- We are proposing a new way of organising care where we have:
- Only one point of entry for everybody to refer to no matter what the home and community service is that the patient requires
- A coordination centre that coordinates all the home and community services a patient needs, for example home nursing and rehabilitation
- Positions called 'Care Managers', there to pick up the early warning signs of someone who might develop complex problems later on in life
- Specialist multi-disciplinary services to help treat the small amount of people who have many and/or complicated health problems
- One assessment process built on by each person who sees the patient and this becomes the care plan for everyone to use

WHAT GROUP OF PEOPLE DO WE THINK THIS WILL HELP?

People who are over 18 years of age and live in our district and have the following:

- Chronic illnesses, for instance chronic respiratory diseases
- Conditions more commonly associated with older people, for instance dementia
- The need for home based services such as nursing and rehabilitation

We believe these changes will mean people have a better experience of services and better health.

WHAT NEXT?

Our approach will involve changes across many services. The approach to undertake these changes has not yet been finalised and we hope that responses to this consultation will help inform key decisions. We hope to have much of this proposal in place by July 2005.

MAKING A SUBMISSION

This document includes a series of questions to assist you with your submission and a submission booklet to write your comments. If you prefer not to use the submission booklet to record your comments, just write your comments on a separate piece of paper.

C&C DHB invites comments on the questions contained in this document from consumers, providers of health and disability services and the general public.

The consultation period begins on 15 June 2004 and submissions will be received until 5.00pm on 28 July 2004. A summary of submissions will be publicly available as soon as practicable after the consultation period finishes.

Submissions can be made in the following ways:

- Adding your comments to submission document and posting them to address below
- Making your comments on a separate piece of paper and posting them to the address below
- By email to Andrew.Downes@ccdhb.org.nz

Verbally at the following public panels:

DATE + TIME	VENUE
15th July 2004 - 6.00pm to 8.00pm	Kapiti Community Centre 15 Ngahina St Paraparaumu
19th July 2004 - 6.00pm to 8.00pm	Kiwi Room Community Meeting Room North City Shopping Centre Porirua
20th July 2004 - 6.00pm to 8.00pm	Level 1 Lotteries Commission Bldg, 54-56 Cambridge Terrace, Wellington

Please call Peter Barton on 04 918 1141 to book a time for these.

- At the following Hui:

DATE + TIME	VENUE
26 th July 2004 5.30pm – 7.30pm	Level 1 Lotteries Commission Bldg, 54-56 Cambridge Terrace, Wellington

- At the following public forum:

DATE + TIME	VENUE
23 rd June 2004 10.00am – 2.00pm	West Lounge, Level 3, Westpac stadium, Aotea Quay, Wellington

If you require, or know someone who requires, additional copies of the consultation document, for instance in a different format, please contact Naomi Guyer on (04) 803 1112. The consultation document can be downloaded from the C&C DHB web site: (www.ccdhb.org.nz). More supporting information for this proposal is available on request. Please contact Naomi Guyer on (04) 803 1112 for this.

Please return only one copy of your submission, ie. If you post your completed submission please do not fax your comments as well.

RETURNING YOUR SUBMISSION

All submissions must be received no later than 5.00pm on Wednesday 28 July 2004. Please return your submissions in the booklet provided to:

Andrew Downes
Project Manager
Planning & Funding Directorate
Capital & Coast DHB
54-56 Cambridge Terrace
Private Bag 7902
WELLINGTON

Thank you for taking the time to read through this proposal and we look forward to receiving your submission.

ABBREVIATIONS USED IN THIS CONSULTATION

- ATR – Assessment Treatment and Rehabilitation service. This is a hospital based service comprising of multi-disciplinary teams that provide rehabilitation for people following an injury or disease. Multi-disciplinary teams are a mixture of nurses, doctors, and therapists for example speech and language therapists and occupational therapists
- ACC – Accident and Compensation Corporation
- C&CDHB – Capital and Coast District Health Board
- CHS – Community Health Service. This is the hospital based service that provides community nursing, some home care and community therapies such as physiotherapy and occupational therapy
- DHB – District Health Board
- DSS – Disability Support Services. A funding stream from the Ministry of Health
- HHS – Hospital and Health Service. The hospitals managed by the District Health Board at Kenepuru, Newtown and Kapiti
- MDS – Minimum data set. This is the name of the assessment tool that we are considering using and refers to the minimum amount of information needed to complete a comprehensive assessment covering health and psycho-social needs
- NASC – Needs Assessment and Service Coordination agency. In this district this is Capital Support. Capital support assesses people for their disability related needs and organises relevant care packages for people to support them at home
- NGO – Non governmental organisations, any non-profit organization that is independent from government, for example Age Concern, the Arthritis Foundation or the Cancer Society
- PH – Personal Health. A funding stream from the Ministry of Health
- PHO – Primary Health Organisations

SCOPE OF THE PROPOSAL

This proposal includes the following groups of people, funding and services.

POPULATION

- Adults over 18 years of age with chronic illness and/or high health needs, for instance chronic respiratory and congestive heart diseases
- Older people, including people aged 65+ and the 50-64 age group with early onset of conditions more commonly associated with older age, for instance Alzheimers dementia
- All people with a short term need for home based nursing, therapy, support or other home based care

who are resident within the area covered by C&CDHB Wellington, Porirua and Kapiti.

FUNDING

- Personal Health (PH)
- Disability Support Services (DSS) for older people and adults with chronic illness
- Mental Health support services for older people

SERVICES

The proposal will directly change the way the following services are delivered:

- Clinical and support needs assessment
- Service coordination
- Short term home and community care, for instance post discharge care
- Specialist services for older people including geriatric assessment, treatment and rehabilitation and psychiatry of old age services
- Organised stroke services
- Rehabilitation and allied health services

to ensure coordinated and more flexible access to:

- Home support including personal care and household management
- Home and specialist community nursing services
- Maori services
- Pacific services
- Mental Health support services for older people
- Services provided by primary, community, voluntary and non governmental organisations (NGOs)
- Disability support services for older people including:
 - Respite care and carer/family/whanau support
 - Day programmes
 - Aged residential care
 - Packages of care provided through flexible funding or direct payment
- Community allied health services including occupational therapy, physiotherapy, speech and language therapy, dietetics and social work
- Services provided through ACC
- Other home based primary and community care services such as medication management.

This programme will not directly change services and funding for:

- Non aged related disability support services
- Non aged related mental health services for people with severe mental illness
- Child health services for people under 18
- Elective and acute hospital services for specific conditions such as cardiology and orthopaedics

These services are subject to separate service development processes through the District Health Board (DHB) and Ministry of Health.

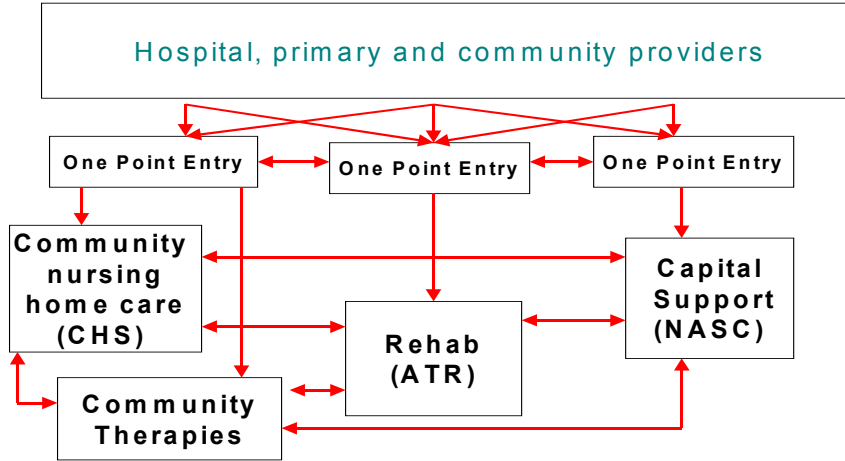
Younger people with disabilities will continue to access disability support services through Capital Support, the Needs Assessment and Service Coordination service (NASC). This service is being developed to increase its responsiveness and to provide services on an inter-sectorial basis, for example across housing and income support.

Younger people with severe mental illness will continue to access services through existing structures. C&CDHB has committed to developing community based mental health services.

Question 1

Are there services, funding or groups of people not mentioned whom you think should be included?

OUR CURRENT COMMUNITY SERVICE CONFIGURATION



The diagram above represents the community based services provided through Capital and Coast DHB hospitals. This gives an idea of the potential confusion there is for both consumers and providers negotiating through several 'one point of entry', processes for the many services that exist. For simplicity, Mental Health services and its 'one point of entry' have not been included in this diagram.

This structure is not only split into many services it is also split by what type of funding each service receives.

Because of this split in structure and funding, each service has its own:

- Referral criteria
- Assessment processes – much of which is not shared with other services
- Criteria for providing different types of home, primary, community and specialist services

For instance, someone can have short term nursing from one service but longer term home care services from another service. Both services require separate referrals and assessments, and care is not always coordinated. Many people are seen by more than one service but these services don't always 'add up to a whole'.

These services are in fact providing care to the same group of people, those who have chronic disease and older people with disability.

PROBLEMS WITH CURRENT ARRANGEMENTS

This picture of split funding and services causes numerous problems for both consumers and providers. These are summarised below.

- Confusion over boundaries between services – who does what?
- Separation/fragmentation of services resulting in a lack of coordination between services
- Duplication of service provision
- Duplication of assessment processes using valuable time and resources
- Duplicated, referrals, administration systems and points of entry
- Difficulties at discharge/transfer between services
- Referrers not wholly aware of services available or who to refer to
- Clinical staff not always aware that other services are involved with someone
- Communication difficulties between services
- Services only being involved at crisis points and working on the back foot
- Services spending large amounts of time trying to coordinate care with other services when access criteria and service boundaries get in the way
- Service gaps, for instance home based 'slow stream rehabilitation', Maori and Pacific services
- Not having access to other services' assessment and care plan information
- No overall care plan or pathway for people with multiple needs

Under current systems this is what happened to Margaret:

Margaret was 63 when she had to take early retirement because of chronic illness – respiratory disease and congestive heart failure. Since Margaret was having trouble even being able to walk to her car and letterbox, her GP knew that she would need support to achieve her main goals – to remain living at home and be able to go to Bridge card games, including national championships in other towns. The GP sent a referral to the Needs Assessment / Service Coordination (NA/SC) agency, but this was eventually declined on the basis that Margaret's needs were "personal health" and not "disability support". Another referral was made to the Community Health Service, however, this was also declined as her needs were considered "long term and age related".

A short time later Margaret was hospitalised with exacerbation of her respiratory disease. Multiple assessments followed from physicians, an occupational therapist, a physiotherapist, a social worker, as well as a district nurse and the same NA/SC service that had earlier declined her referral. Margaret felt frustrated having to tell her story so many times to different strangers when she was especially unwell.

Home support, including home help and home oxygen, were put in place to aid her discharge from hospital but her family had to intervene to prevent those services being taken away after the six week post discharge period.

Overall this gives a picture of a 'system of care' that despite the best efforts of people working within it lacks responsiveness. There are duplicated processes, no one has overall responsibility for care planning across clinical and support needs and there is confusion as to who can do what for whom.

Question 2

Is this a good summary of problems from your point of view?

THE CONTEXT OF THE PROPOSAL

Our proposal has been developed within the context of the following government strategies:

- The New Zealand Health Strategy
- The New Zealand Disability Strategy
- Health of Older People Strategy
- Primary Health Care Strategy
- He Korowai Oranga Maori Health strategy
- Pacific Health and Disability Plan

and within the direction set by the

- C&CDHB Strategic Plan
- C&CDHB District Annual Plan

Taken together these emphasise the importance of developing services within the primary care and community sector and the need for collaboration and co-ordination between providers across all sectors, ultimately integrating all services across the 'continuum of care'.

A 'continuum of care' is defined as,

'.....an integrated response to health and disability support services.....where providers coordinate their services, working closely with the consumer, family, whanau and carer to provide services that appear seamless to the consumer'.

As a DHB we are now in a position to change the way we integrate home, community, primary and specialist services following the devolution of disability funding for older people from the Ministry of Health. This provides C&CDHB with opportunities to decide how these funds can be managed in conjunction with other funding streams and other stakeholders to gain flexible service delivery and the best outcomes for consumers.

This is supported by the fact that we now have large coverage by Primary Health Organisations (PHOs), about 89% of the population are enrolled. PHOs already play an important role in home and community care and this can be strengthened and recognised through closer links with specialist services.

Our proposal acknowledges that the strongest relationship most consumers have from a health point of view is with primary and community care services.

OUR VISION AND OBJECTIVES

THE VISION

People and their carers and family/whanau receive co-ordinated and accessible home, community, primary and specialist care that pro-actively supports their ability to achieve their lifestyle goals.

Home, community, primary and specialist services will be flexible, focus on best care for the consumer, and support whanau well being and positive ageing.

OBJECTIVES OF THE PROPOSAL

Broadly speaking, we think our proposal will mean that people who use home, community, primary and specialist services will:

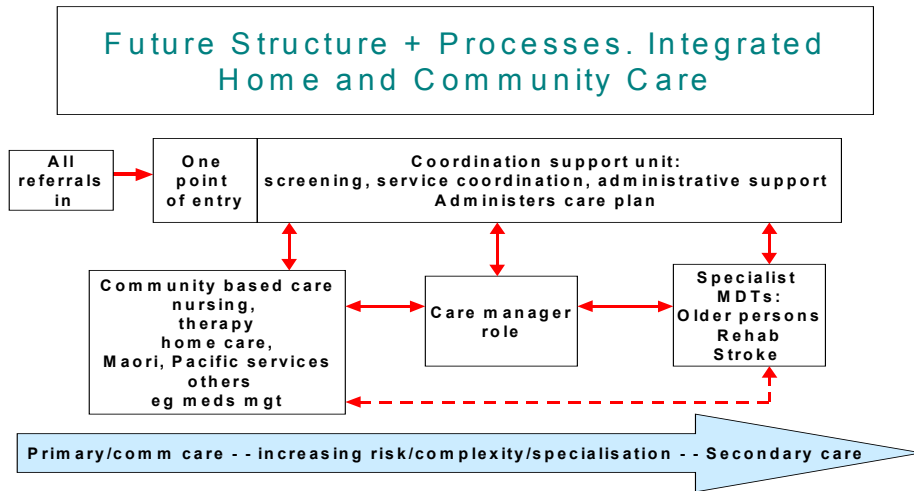
- Be more satisfied with the care they receive
- Not have to wait as long for all their care to be organised and provided
- Have the right care that meets their needs and is provided in more flexible and appropriate ways so Maori and Pacific people, people with complicated health problems and those on low income will not fall ‘through the cracks’
- Only have to refer to one place for all the services that someone needs
- Will not have to repeat their stories to many different health professionals as all the assessment information will be shared between services
- Will have care put in place at an earlier stage to prevent problems occurring in the first place
- Will not have different health professionals from different services turning up to do the same thing – everyone will know what is happening

Question 3

Do you agree with the vision and what we’re trying to achieve?

OUR PROPOSAL

The key changes we propose are:



- Developing one assessment and care planning process across all services using evidence based tools that continually build on previous assessments and care plans, rather than the duplicated and fragmented processes we have at present
- Combining funding for home, primary, community and specialist services at the point of entry for those services. This way services can be accessed on a needs basis rather than the current process which is based on:
 - Arbitrarily linking diagnoses to services
 - Funding silos
 - Short term versus long term care distinctions
- A new central care coordination centre to be the single point of entry for all referrals for home and community services. The care coordination centre will integrate care in the home and community setting around the consumer. This will replace the multiple points of entry we currently have
- New Care Manager roles providing early assessment across clinical, social and support needs to reduce onset and progression of chronic disease and disability. The role will provide strong support for, and be closely involved with, primary care. This will replace the historically restricted needs assessment and service coordination for older people that we currently have
- Specialised multi-disciplinary services to provide expert multi-disciplinary assessment and intervention for older people, people who have had strokes and people who need rehabilitation
- Developing more flexible ways of integrating care and support around the consumer in the home setting particularly in relation to home based nursing and therapy/allied health services.

Underpinning the model is the use of one assessment process and one set of assessment and care planning tools for use across home, community, primary and specialist services.

This proposal supports the use of the New Zealand Guideline Group recommended suite of tools, in particular the Minimum Data Set (MDS).

The MDS is a set of tools developed by interRAI (www.interrai-uk.org) a global network of over 40 researchers and clinicians. The MDS tools are 'evidence based' assessment and care planning tools and have been developed over several years, undergoing a rigorous design and testing process. The MDS:

- Provides the minimum assessment required to complete a competent and holistic assessment of an individual. Based on assessment findings the tool triggers further assessment processes/protocols to ensure that all problems are dealt with appropriately
- Ensures that all assessment information is captured so people do not have to tell their stories many times to many services
- Has been shown to improve health outcomes in a variety of settings and across many age groups
- Is more complete in comparison to other assessments and results in fewer 'missed problems'. It uncovers risk factors for later onset of disability that many assessment processes don't pick up
- Will assist sharing of assessment information and care plans in a 'common language' across services
- Provides better care planning information for consumers and also better service planning information for the district as a whole
- Will be adapted for use in New Zealand to take account of the needs of Maori, Pacific, and the requirements for ACC

It consists of assessment and care planning processes that cover a multitude of needs integrating health and social assessment into a single assessment. It approaches assessment from a 'whole person' point of view and covers areas such as:

- Functional ability - someone's ability to walk, manage stairs and dress themselves
- Mental ability - someone's mood or memory
- Sensory ability – someone's sight and hearing
- Social/environmental supports – the strength of someone's social networks and the equipment they might need for home
- Strengths, abilities and needs of the main carer and family/whanau
- Others – someone's diet, medication or any risk factors for increased disease or disability, for example those that predict falls

The assessment is completed with the consumer and is based on the goals, strengths and lifestyle aspirations they identify. The assessment strongly identifies the needs/strengths of the main carer and family/whanau too.

The Care Manager and consumer will use this information to develop a care plan, which will be retained by the consumer and relevant services.

Arthur has had a long standing mental health problem. As he is now getting on in years his mobility isn't so good and he has difficulty managing the stairs, getting in and out of the bath and managing to wash and dress himself at his residence. He has lived there for a number of years and it is funded by mental health. He has been assessed by mental health service coordination who have referred him on to the disability services service coordinator because they feel that his problems do not come under mental health's criteria. Initially nothing happens with the referral because each service feels that the other is best placed to assess and coordinate Arthur's needs. Eventually, it is agreed that Arthur's problems are more related to his ageing than his mental health.

The disability service coordinator carried out an assessment and referred Arthur for further assessments to an occupational therapist and a physiotherapist who completed more assessments. Eventually some short term adaptations to his residence were made, but overall Arthur needed more appropriate accommodation.

There was then a long struggle to find Arthur new accommodation due to agreeing which funding should pay for it, mental health or disability.

Under our model, Arthur will be assessed by a Care Manager who will establish the best package of services for Arthur in the community, so Arthur won't have to wait too long to receive their assessments, treatments or support.

Crucially there will not be any 'pass the parcel' between services and the funding for his new residence and support will be arranged promptly.

The care plan will be administered by a central care coordination service. This service will combine funding for home and community services at the point of referral. For example:

- Home support including personal care and household management
- Community therapy/allied health services including occupational therapy, physiotherapy, speech therapy, and social work
- Home and specialist community nursing services
- Mental Health support services for older people, for example supported accommodation for mental health 'graduates'
- Services provided by community, voluntary and NGOs
- Disability support services for older people including
 - Respite care and carer/family/whanau support
 - Day programmes
 - Aged residential care
 - Packages of care provided through flexible funding or direct payment

The care coordination centre will also link with other home based primary and community care services identified in the care plan, such as medication management, Maori and Pacific services and palliative care services.

The care coordination service will be the first point of entry for all referrals for home and community services. For example, a GP might refer someone to this service for assessment following a fall. The care coordination centre clinical screeners will initially screen this referral to direct the consumer to the correct services first time.

People who are found to have problems that could worsen in the future if not addressed quickly, for example through having repeated falls, will be assessed by a Care Manager.

Building on the screening already completed, the Care Manager would complete a holistic assessment covering all clinical and social needs, for example:

- Functional ability
- Mental ability
- Sensory ability
- Social/environmental
- Diet
- Medication
- Risk factors

Under our current system, if someone is being seen by several services at home and they are admitted to hospital, the ward has to contact each service and professional involved to find out exactly what is happening with the person in the home setting. This normally leads to new referrals and assessment processes that take time to complete. In the new model, the coordination centre will hold the care plan and so the ward will only have to contact the care coordination service. In fact, we envisage that the care coordination centre will have contacted the ward first. If the person already has a Care Manager, this person will be on hand to assist and advise with discharge, this will just be a continuation of the assessment process as opposed to starting all over again.

For people with several very complex problems, the Care Manager will organise assessment by one of the specialist services for in depth comprehensive multi-disciplinary assessment. Building on previous assessment completed by the Care Manager, the specialist service will complete a more involved multi-disciplinary assessment in conjunction with the consumer and agree a care plan that supports the consumer's goals, strengths and lifestyle aspirations. The assessment and care plan will govern access to services. The consumer will hold the assessment and care plan.

Under our current system, if a hospital is discharging someone, the ward has to send one discharge letter to the GP and referrals to all the services that will follow the person after discharge from the hospital. This could be several depending on how many services are required. In the new model, the ward will send out the discharge letter to the GP as normal and one referral to the care coordination centre to organise all the relevant services.

The care coordination service will organise delivery of services identified in the care plan in the most flexible way using providers who are best placed to provide the required services. The care plan will be shared with providers and will be monitored and updated as required by the Care Manager and/or specialist service.

Some people will only have short-term basic needs, for example, a few weeks of support at home to aid recuperation after surgery. In this instance referral to the care coordination centre could, for example, result in provision of home supports or possibly a referral to a physiotherapist or occupational therapist.

Through this process, pathways of care will be built up depending on consumer's needs and not whether they might 'fit' into services or funding.

The components of our proposed system of care are discussed in more detail in the following sections.

CARE COORDINATION SERVICE

The functions of this service will include:

- 1) Single point of entry for referrals for home and community services.

All referrals from the hospital, primary care, GPs and consumers will be sent to this point. Referrals will be registered on a central information system. The service will operate an 0800 telephone number. This will eliminate the multiple referrals going to multiple services for the same person.

- 2) Clinical screening/triage of referrals for home and community services.

Each referral will be screened by clinical screeners for appropriateness for the service(s) that the referral has been sent. This will be a clearly structured decision tree to determine the most appropriate services. This may also include clarification with referrer of previous care or ongoing care and other information as required.

- 3) Providing access to the MDS suite of tools.

Administering the computer based assessment tools used to capture patient information in a single assessment process spanning from screening through to specialised multi-disciplinary assessments.

- 4) Forward referrals onto appropriate service depending on complexity/risk

Referrals will be allocated to the correct services based on complexity, need or risk. This will span from basic short term services like home supports following discharge, to the Care Manager role for assessment and care planning to a specialist team, for example the older persons service for comprehensive in – depth multi-disciplinary assessment and care planning.

- 5) Coordinating and integrating packages of care and support

The care coordination service will administer the overall care plan developed by the consumer and Care Manager and/or specialist MDT. This will involve organising and coordinating services using providers who are best placed to deliver the required services in the most flexible way to integrate care around the person. The service will link with other services for example ACC, housing, and NGOs. All relevant information will be attached to the care plan, for example, who the provider is, what they are providing, when it is provided and who to contact if there is a problem. The service will update care plans as changes occur to ensure they are up to date.

6) Monitor indicative budgets and resource use

The Care Manager and specialist MDT teams will generally manage access to services based on assessment and care plans. The coordination service will monitor indicative budgets and resource use for the services identified previously on pages 8 and 9 and report regularly to the District Health Board.

7) Provide information on relevant home and community support services

The care coordination service will act as a district wide information centre for the range of home, community primary and specialist support services. This will give consumers and providers a resource for accessing the right services.

CARE MANAGEMENT

The Care Manager role will be drawn from people who:

- Are from senior clinical nursing and allied health backgrounds
- Have experience working in a multi-disciplinary environment
- Have post graduate training and/or experience in older peoples health, rehabilitation and/or chronic care management

The role will be strongly linked with primary care for early identification of people who are at risk of onset or progression of chronic disease and disability. The role will mobilise services and interventions at an early stage to reduce progression of disease and disability. This relates to consumers who:

- Have risk factors/unmet needs identified on attendance to a health professional
- Have not had comprehensive assessments in the previous six months
- Have multiple problems and require care coordination over several services

The Care Manager role will:

1) Discuss goals, strengths and lifestyle aspirations with the consumer. Complete a comprehensive assessment covering the minimum areas required to identify problems across both clinical and social needs in conjunction with the consumer.

2) Agree a care plan covering clinical and social needs in conjunction with the consumer. The assessment and care plan will govern access to services and this will be administered by the care coordination service.

3) Have oversight of the care plan across primary, community and secondary care linking with other services as required, for example ACC, housing services and NGOs. The role will review, monitor and update the care plan as required.

4) Be the first point of contact for consumers

5) Provide clinical and non-clinical education and consultation across all sectors to promote best practice in care for the consumer.

6) Assist with discharge planning as required from the hospital.

This role will replace many existing duplicated/fragmented roles, for example Needs Assessment, Service Coordinator and liaison nurse roles. The exact number of positions and caseload for the role is yet to be defined. However we estimate that there could be up to 30 of these roles in this DHB with a caseload of up to 40 consumers at any point in time.

We also need to consider who employs Care Managers, (for instance PHOs or the hospital), where they are based, (for example with primary care providers or specialist teams), the links that they need to have with specialist teams and primary care services, and their training and supervision across the district as a whole.

Under our proposal, Margaret's story on page 10 would be different. Hopefully it would go something like this...

Margaret's GP knew that she would need support to achieve her goals. He was able to refer to one point – the care coordination service - which arranged for a care manager to see Margaret. The Care Manager completed an assessment with Margaret, drawing upon the expert advice and input from the older person's specialist service in relation to some of the more complex clinical issues. On the basis of this information and Margaret's own goals and lifestyle aspirations, a care plan was developed with Margaret which identified the services she would receive:

- Home oxygen and a home nebuliser
- Hand rails and a bath board installed in the home so Margaret could manage her own bathing
- Household management, to prevent activities such as vacuum cleaning worsening her shortness of breath.

These services were rapidly organised by the care coordination service which was able to ensure that they were delivered in a coordinated way by the best placed provider. The Care Manager also liaised with Margaret's GP in relation to some medication changes which were recommended by the Older Person's Service.

With these changes Margaret's ability to carry out activities of daily living improved along with her mobility – most importantly for Margaret she was still able to get to the Bridge club to see her friends.

SPECIALIST MULTI-DISCIPLINARY SERVICES

These services will provide support for the Care Manager role in the management of people with complex problems and will consist of a specialist older persons service, organised stroke services, and a rehabilitation service.

OLDER PERSONS SERVICE

The Older Persons service will support consumers who have specialist needs. This relates to people whose condition(s) is of such severity or complexity that it is beyond the capacity of the referring service to manage without comprehensive in depth multi-disciplinary assessment, advice and intervention. This relates to older people:

- With established multiple complex health, functional and/or social problems, who are of vulnerable health
- Who are experiencing irreversible deterioration of their health or functional/mobility status and their safety is compromised
- Who are at risk of hospital admission or have had unplanned in-patient medical/surgical admissions or emergency department attendances
- Who have rapid unexplained increases in home and/or carer/family/whanau support
- Who are losing functional skills to a degree that places significant pressure/distress on the family/caregiver which may cause the family/caregiver's health status to be compromised
- Who are at risk of risk no longer being able to stay in their own residence

The older persons service will:

- Have strong links with hospital services and primary care through clinical pathways, referral guidelines and education on best practice for care of the older person.
- Provide expert clinical and non clinical education and consultation across all sectors promoting best practice in care for older people across all services.
- Build on the MDS assessments completed previously, usually by the Care Manager, to give a complete in depth multi-disciplinary assessment covering all clinical and social needs. This will in be done in conjunction with the consumer building on their goals, strengths and lifestyle plan.
- Agree comprehensive care plans with the consumer and provide specialist interventions or referral on to other services as required.
- Assist with discharge planning as required from the hospital.
- Provide strong clinical support for primary care services and Care Managers.

DEDICATED STROKE TEAM

The organised stroke service will consist of a dedicated stroke team with a 'lead clinician'. This service will have responsibility for managing the care of all people with acute strokes across medical and rehabilitation settings. The service will promote best practice for the management of stroke when it occurs, including prompt assessment and treatment and secondary prevention.

MULTI-DISCIPLINARY REHABILITATION SERVICE.

There will continue to be an in-patient and community multi-disciplinary rehabilitation service.

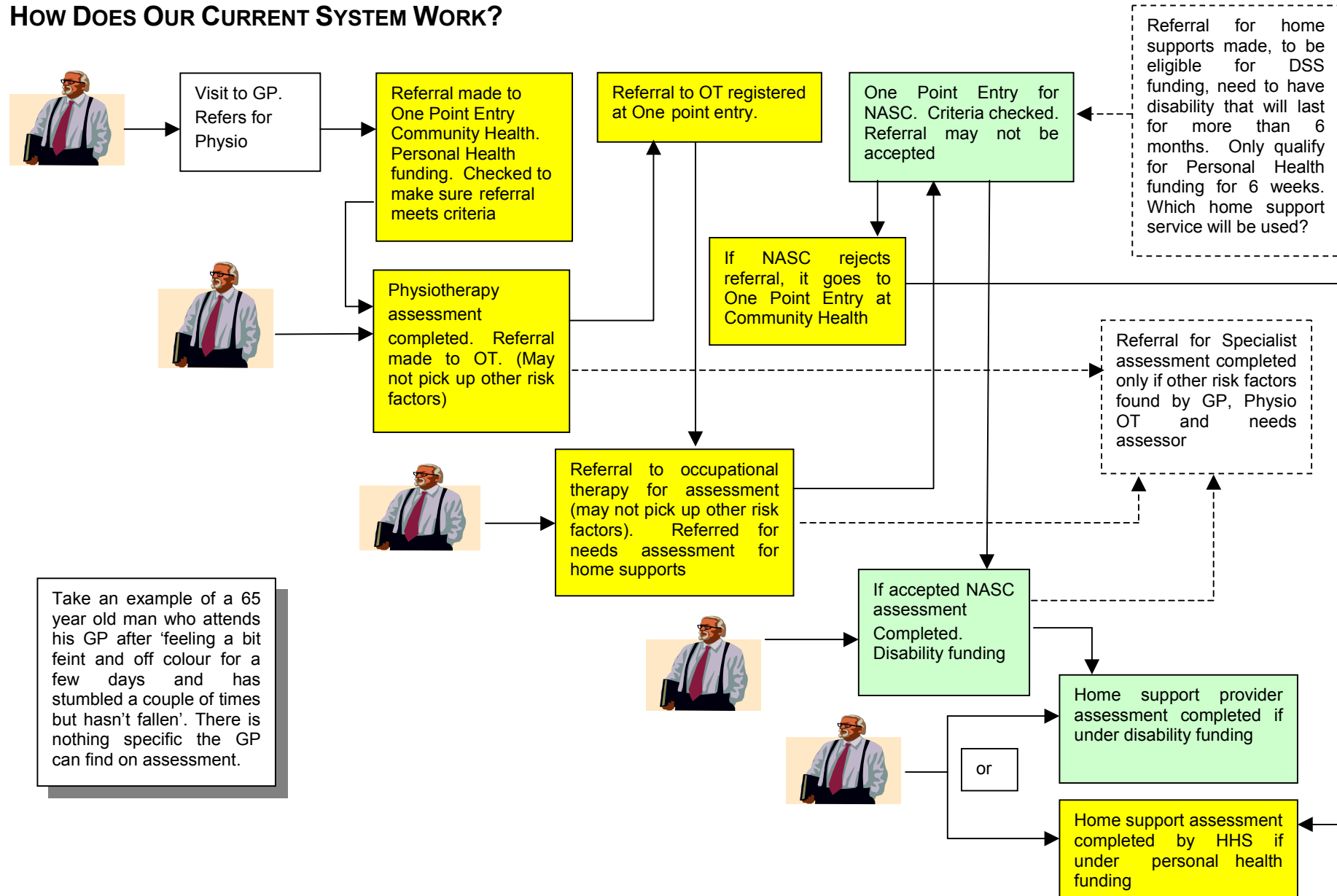
CONFIGURING THE SPECIALIST TEAMS

These specialist services will be staffed by rehabilitation specialists, geriatricians, nurses, occupational, therapists, physiotherapists, psycho-geriatricians, social workers, clinical pharmacists and others as required.

The exact mix and make up of the various teams, services and their linkages are yet to be defined. We expect that allied health and nursing staff will be able to work across teams and services. For example, a physiotherapist might have part of their role with the older persons specialist team and part with the rehabilitation or stroke team.

How the services will work in practice is shown in the following diagrams and tables.

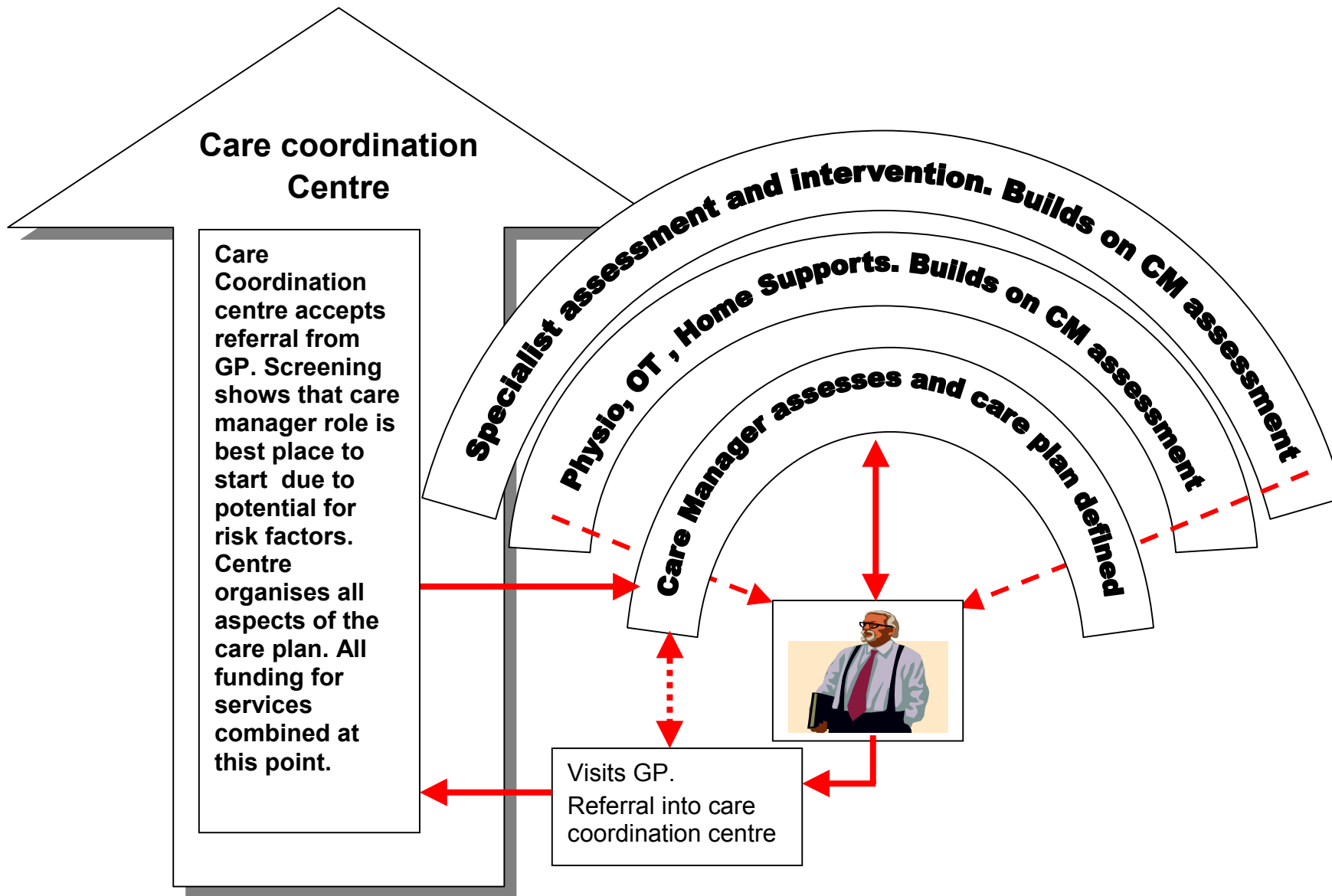
HOW DOES OUR CURRENT SYSTEM WORK?



Take an example of a 65 year old man who attends his GP after 'feeling a bit faint and off colour for a few days and has stumbled a couple of times but hasn't fallen'. There is nothing specific the GP can find on assessment.

EVENT	ACTION	PROBLEM
Consumer attends the GP practice. GP completes assessment. Risk factor for fall noted	GP sends a referral for Physiotherapy assessment to one point of entry'	Not all of risk factors for falls or other problems may be picked up at initial consult with GP. May not get referral to specialist team
Physiotherapy assessment	Assessment completed and interventions started Further problems noted and referral forwarded onto occupational therapy	Duplication of referral process. Duplication of some assessment data Not all of risk factors for falls or other problems may be picked up at assessment May not get referral to specialist team
Occupational Therapy assessment	Assessment completed and interventions started Further referral for home supports made to Needs Assessment Service Coordination agency	Not all of risk factors for falls or other problems may be picked up by assessment Duplication of referral process. Duplication of some assessment data May not get referral to specialist team
Referral for needs assessment	Referral has potential to be passed between services due to access criteria and funding streams being different for two Home Support services. Needs assessor completes assessment and forward referral to home support agency. Home support agency completes another assessment	Duplication of referral process. Duplication of some assessment data Length of time to receive service
		Who owns the care plan? Who is reviewing ongoing care? Consumer has a long period of time before they have received all relevant assessments and interventions, not all risk factors may be identified, therefore has increased time 'at risk'.

HOW MIGHT OUR PROPOSAL WORK?



EVENT	ACTION	PROBLEM RESOLVED
<p>Consumer attends the GP practice. GP completes assessment. Risk factor for fall noted</p>	<p>GP refers for assessments to care coordination service</p>	<p>Duplicated referrals going to duplicated 'one point entry' processes. All services funded by one funding stream so no potential for funding splits to exclude consumer from services.</p>
<p>Care coordination clinical screener screens referral and decides that care manager role best placed to start assessment process</p>	<p>Care manager role completes comprehensive assessment. Identifies additional risk factors. Care manager/care coordination centre 'own' the care plan. Care manager refers on to appropriate services. Care coordination centre provides all administration support This care plan is communicated to all services including GP</p>	<p>Higher chance of establishing all risk factors from the outset. Quicker access to specialist team</p>
<p>Referrals and care plan received by appropriate services</p>	<p>Services complete additional assessment details not covered in CM assessment</p>	<p>Reduces the amount of information that is reassessed and the number of reassessments Reduces the length of time before consumer receives full 'package' of assessment and intervention</p>
<p>Care plan monitored by care manager/care coordination service</p>	<p>Care manager reviews care plan in conjunction with services.</p>	<p>There is a care plan that arches over all services and funding streams</p>

The table below broadly outlines the differences between the current 'system' and the one that our proposal envisages.

OLD	NEW
Many points to enter the system	One entry and coordination point
Services working 'un-connectedly' with service splits at point of delivery	Full integration at the point of entry and around the consumer
Different funding mechanisms for care	Fully integrated funding at the point of entry
Different unrelated access criteria to different services, assessments and interventions	Single set of access criteria for all services linked to assessment and need
Many repeated assessments covering the same information	Single assessment process with fewer assessments and less repeated information
Emphasis on treatment	Emphasis on prevention, rehabilitation and management
Many duplicated administration systems	Fewer administration systems
No overall care plan	One overall care plan

Question 4

Do you agree the model we're proposing will improve services? What other changes or solutions do you suggest?

DEVELOPING HOME, COMMUNITY, PRIMARY AND SPECIALIST CARE SERVICES

The changes to the assessment, care planning, and coordination processes outlined in our proposal will only result in improved outcomes for consumers if appropriate services are available to meet assessed needs.

C&C DHB is already undertaking ongoing service development in home and community care. Initiatives and priorities outlined in our District Annual Plan include:

- Culturally competent services for Maori and Pacific people
- Improved end of life/palliative care services
- Better supporting both formal/paid and unpaid/informal carer/family/whanau of older people
- Intersectorial initiatives to improve community care options for older people – for example supported housing developments
- Services to reduce the incidence and impact of falls
- Medication management services
- Evaluating options for reducing isolation and loneliness amongst older people, including evaluating befriending services

Our proposal assumes ongoing development of these types of services as funding priorities allow. More information on these initiatives can be found in our District Annual Plan under section 5.6 – *Achieving Integrated Care* (available on our website: www.ccdhb.org.nz). Implementation of the assessment tool and related dataset proposed in this document will also provide C&C DHB with better information about the service needs of older people and adults with chronic illness for future years.

In the short term, increased flexibility and availability of home nursing, home based personal care, and community therapies services is also essential for increasing home, community, primary and specialist care options for people in our district. One option to achieve increased flexibility is to:

- Seek proposals from providers for the provision of home based nursing on a seven day a week basis (at present this service is provided only by our hospital on a more limited basis)
- Seek proposals from providers for the provision of community and home based therapy services (including occupational therapy, physiotherapy and social work) on a seven day a week basis

The key is to get the right mix of providers for these services. Future providers may include a combination of primary care providers, home care agencies, the hospital and others.

Question 5

Do you think seeking proposals is the best option for ensuring the best mix of providers and flexibility of services?

We expect these changes will allow us to fund home based care on a package basis in future. For example a provider might be funded to deliver a combined package of nursing, physiotherapy and personal cares to someone who has experienced a stroke. The provider will be responsible for coordinating those services into the home and ensuring the caregiver is trained and supervised by an appropriately skilled nurse and/or physiotherapist.

We will also extend the current flexible funding system used by the Needs Assessment and Service Coordination agency. Flexible funding is a discretionary funding pool which is used to purchase services on a one-off basis where usual formally contracted services are not the best option for supporting an individual and their family/whanau. On rare occasions it is also used to directly fund an individual so that they can purchase services for themselves. Flexible funding allows for innovative care packages to be put in place following assessment. At present it is used particularly to support Maori and Pacific people where culturally appropriate service solutions are not available.

We will extend flexible funding in terms of the both the total dollar amount available under the scheme, and the range of services which can be purchased on a flexible basis to meet individual needs.

In future we expect the new arrangements will allow us to develop services that prevent or reduce the need for acute hospital care and delay entry to residential care. Other options being considered for future development include:

- Rapid response teams
- Hospital in the home
- Enhanced primary care
- Home support services and/or residential services that have a slow stream rehabilitation component and emphasis

REDUCING HEALTH DISPARITIES

Our District Strategic Plan identifies reducing health inequalities between the general population and Maori, Pacific peoples, and low income groups as a key priority. We believe the changes proposed in this document will strongly contribute to this goal through:

- **Proactive, comprehensive assessment.** Under our proposal assessment would be available at an earlier stage which will help ensure that risk factors for disease and injury are identified earlier. In addition, assessment will include consideration of the care givers' and family/whanau's strengths and needs.
- **Easier access to services.** Under our proposal services will follow the care plan which is developed as a result of the assessment. As access to assessment is key to accessing services, establishing Care Managers who are able to work effectively with disadvantaged groups is our first priority.
- **More flexible service delivery and support.** Under our proposal provision of home nursing, allied health, and other homecare services will be delivered more flexibly. We will also be able to better support more families through innovative or individualised services by extending flexible funding and direct payment options.

These changes should disproportionately improve access to appropriate services for people from disadvantaged groups. The majority of consumers of integrated home and community services will be from low income groups. There will also be specific implications for Maori and Pacific peoples health.

MAORI

Te Plan sets out C&C DHB's direction for improving Maori health in the district. We believe our proposal will help implement *Te Plan* through the changes outlined above. Specifically:

- A whanau strengths based approach to assessment, care planning and service delivery will be implemented
- Maori care managers who are attached to Maori primary care providers within PHOs will be better placed to identify risk factors and intervene before poor outcomes eventuate
- There will be greater flexibility in the ways in which Whanau can be supported.

These changes should improve Maori health outcome and reduce disparity in our district.

The *Pacific Health Action Plan* sets out C&C DHB's key actions for improving the health of Pacific people in the district. The Plan builds on previous C&C DHB reports, including *Capital Support in the lives of Pacific Peoples with Disabilities*. We believe the proposed changes will help implement the actions and recommendations of these plans and reports through the changes outlined above. Specifically:

- Access to assessment and services will be easier for Pacific peoples through one point of referral, one assessment process, and better integrated services across primary and secondary care.
- Pacific Care Managers will bring a Pacific perspective to mainstream service delivery across both primary and specialist care.
- Pacific families will have access to a greater range of home and community options for caring for their elders and chronically ill family members.

...I had to ring many agencies to get the person... it wasn't till I spoke to others – doctor, district nurse, community health worker... I was told that the Service Coordinator was supposed to organise these services.

These changes should improve the health and disability status of Pacific peoples in our district.

PROPOSAL FOR DEVELOPMENT WITHIN C&CDHB

Integrating home, community, primary and specialist services in the way proposed will involve considerable change across the following services:

- Community nursing
- Home help and personal care
- Community therapies/allied health
- Assessment Treatment and Rehabilitation
- Needs Assessment and Service Coordination

A transition period will be inevitable as new components are introduced in a controlled manner. The following principles will guide developments:

- The outcome of the development must improve the integration of care across services and move away from the current fragmented approach
- The best provider or mix of providers will deliver services in a flexible manner
- All developments will be clearly communicated in a timely manner
- All developments will occur in a controlled fashion
- The C&CDHB workforce is valuable to C&CDHB and maintaining their skills and knowledge within the district is important to continually improve services
- Developments will disrupt current service delivery as little as possible
- Standard change management procedures apply, as there are likely to be changes in the configurations/roles of some positions
- Staff surplus will be a last option and redeployment options within the DHB will be explored

With the above principles in mind, consideration has been given to a range of approaches to developing this proposal. These approaches range from a restructure of existing services and re-design of existing processes, to use of contestable processes to achieve the best mix of providers of various services.

Depending on the approach taken, some positions may transfer to a new service or even new providers. If this does occur, it is anticipated that any transfer will occur to substantially similar roles. These changes will be made in a planned and controlled manner so that current service delivery is not interrupted. On balance, our proposed approach is as follows:

- Care Manager roles will be progressively introduced as funding and workforce constraints allow. Establishing Care Managers for disadvantaged groups is the first priority – this includes Care Managers who are able to work effectively with Maori and Pacific people, and people who are socio-economically disadvantaged. Care Managers would be mainly employed by Primary Health Organisations and based with primary care providers. The Care Manager role will be supported by a DHB wide workforce development programme covering training and supervision.
- The specialist services will be formed as soon as practicable through a re-configuration of current hospital services, for example, the ATR service
- The Care Coordination Service's key functions and specifications will be defined, and proposals invited for establishment of the service from providers who have expertise in this area, including existing providers
- Once the above components are in place, proposals will be invited from providers for the flexible delivery of community and home based therapy and nursing services. For example from the hospital, primary or other community providers.

Question 6

Do you agree that the Care Managers should be employed by PHOs and based with primary care providers? Do you agree with the role and how it is defined?

It will be important for Care Managers, the specialist services, and the Care Coordination Service to work closely together along with Primary Health Organisations, community providers and other hospital services.

To ensure this occurs, a joint clinical and service development group could be facilitated by the District Health Board.

The group would be responsible for developing and overseeing operational, clinical, and resource issues as the services develop, including:

- Clinical pathways
- Referral protocols
- Evaluation and monitoring of services
- Indicative budget/resource management
- Continuous quality improvement

If we start in October 2004, we hope to have the majority of these initiatives in place by July 2005. However some aspects will take longer, for example developing proposals for the flexible delivery of community and home based services and developing clinical pathways.

This proposed approach to implementing the proposal has not yet been finalised and more detailed service planning is still required. Responses to this consultation will help to inform key decisions.

Question 7

Do you think the approach to change suggested above will achieve the objectives of this proposal? What other approaches would you suggest?

EVALUATION AND MONITORING OF IMPROVEMENTS

International experience and evidence tells us that through this approach we will see changes in the unplanned use of hospital services and residential care in the district. Both will decrease, while use of community services will increase. Overall, health outcomes for our district will improve, especially in the older age groups.

We will use the following indicators, amongst others, to evaluate our proposal.

- The overall consumer satisfaction with access to and provision of care
- The overall health outcomes for the consumer group
- The effectiveness in reducing health inequalities
- The use of hospital services by the consumer group that are not planned
- The amount of preventable hospital admissions each year
- The amount of older people moving from their homes to residential care facilities
- The amount of community and home based services accessed by the consumer group
- The amount of community and home based services accessed by Maori, Pacific and other ethnic communities within the consumer group

Overall evaluation and monitoring of service developments and health improvements will be undertaken by the District Health Board and reported six monthly.

Submission Booklet

Discussion document for the Integration of Home, community, primary and specialist Services in the Capital & Coast DHB district

Submissions close at 5.00pm on 28 July 2004

Please detach and return to:

Andrew Downes
Project Manager
Planning & Funding Directorate
Capital & Coast DHB
54-56 Cambridge Terrace
Private Bag 7902
WELLINGTON

Please use this submission booklet (also available on our website (www.ccdhb.org.nz) when making a submission as this format will assist C&C DHB in effectively analysing the submissions. You do not have to answer all the questions if you do not want to

This submission was completed by: *(name)* _____

Address: *(street/box number)*: _____ *(town/city)* _____

Organisation: *(if applicable)* _____

Position: *(if applicable)* _____

Ethnicity

Maori	<input type="checkbox"/>
NZ	<input type="checkbox"/>
European	
Pacific	<input type="checkbox"/>
Other	<input type="checkbox"/>
(please specify)	

Please tick the box that best describes you or your organisation
(Tick only one box in this section)

Primary Care Provider	<input type="checkbox"/>	Carer/Family/Whanau	<input type="checkbox"/>
Secondary Care Provider	<input type="checkbox"/>	Service Provider & Service User	<input type="checkbox"/>
Support Group	<input type="checkbox"/>	Patient/Service User	<input type="checkbox"/>
Private Citizen	<input type="checkbox"/>	Runanga	<input type="checkbox"/>
Other (please specify)			

Please describe what type of organisation you work for (if any)
(Tick only one box in this section)

Non-governmental Organisation (NGO)	<input type="checkbox"/>	Local Interest Group	<input type="checkbox"/>
Central Government Agency	<input type="checkbox"/>	Local Government	<input type="checkbox"/>
Not responding as part of an organisation	<input type="checkbox"/>		
Other (please specify)			

Please indicate how many additional people (other than the writer) contributed to this submission: _____

Your submission may be requested under the Official Information Act 1982. If this happens, C&CDHB will release your submission to the person who requested it. However, if you are an individual as opposed to an organisation, C&CDHB will remove your personal details from the submission if you check the following box:

I **do not** give permission for my personal details to be released to persons under the Official Information Act 1982.

Do you wish to receive a copy of the summary of the submissions?

All submissions will be acknowledged by C&C DHB and a Summary of Submissions will be mailed to all those who request a copy. The summary will include the names, organisations and location of all those who made a submission.

Question 1 (refer to pages 7-8)

Are there services, funding or groups of people not mentioned whom you think should be included?

Yes No

Comments:

Question 2 (refer to page 10)

Is this a good summary of problems from your point of view?

Yes No

Comments:

Question 3 (refer to page 12)

Do you agree with the vision and what we are trying to achieve?

Yes No

Comments:

Question 4 (refer to pages 13-27)

Do you agree the model we're proposing will improve services? What other changes or solutions do you suggest?

Agree that the model will improve services

Disagree, the model will not improve services

Comments:

Question 5 (refer to page 28)

Do you think seeking proposals is the best option for ensuring the best mix of providers and flexibility of services?

Yes No

Comments:

Question 6 (refer to page 33)

Do you agree that the Care Managers should be employed by PHOs and based with primary care providers? Do you agree with the role and how it is defined?

Yes the role should be PHO based No the role should not be PHO based

Agree with definition of role Disagree with definition of role

Comments:

Question 7 (please refer to pages 33-34)

Do you think the suggested approach to change will achieve the objectives of this proposal? What other approaches would you suggest?

Agree with the approach Disagree with the approach

Comments:

Question 8

Are there any additional comments you would like to add? Please give reasons.
