

Under our current system this is what happened to Margaret:

Margaret was 63 when she had to take early retirement because of chronic illness affecting her heart and lungs. 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 aim of living at home and being able to go to Bridge card games. The GP sent a referral to the Needs Assessment & Service Coordination (NASC) agency, but she was declined because she didn't fit the 'criteria' for the service.

Another referral was made to the community nursing service, however, this was also declined because she didn't fit the 'criteria' for that service either.

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 the same community nurse and NA/SC services 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.

Eventually home support, including home help and home oxygen, were put in place to aid her discharge from hospital. However she could only have these for six weeks though, as this was one of the 'criteria' to get these services, so her family had to intervene to prevent those services being taken away.

WHAT DO WE WANT TO ACHIEVE WITH THIS PROPOSAL?

We think our proposal will mean that people who use home and community based 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

THERE ARE THREE PARTS TO OUR PROPOSAL

A CARE COORDINATION SERVICE

This will:

- Be the single point of entry for all referrals for all home and community services
- Screen all referrals for home and community services to make sure that they go to the right services first time
- Coordinate all packages of care and support, linking with ACC, housing, community, voluntary and non-governmental organisations (NGOs) eg Age Concern and Arthritis Foundation, as required
- Be a central place for information about the range of services and care available

CARE MANAGEMENT ROLES

Senior nurses, social workers and other allied health professionals will be employed as Care Managers (mainly by PHOs) and will be based with primary care services. These positions will:

- Assess people who are already in contact with health services and identified as having risks or un-met needs.
- Agree a care plan with the person that is in line with what they want, what they need and will help prevent the onset or worsening of problems later on in life
- Have oversight of the care plan, reviewing and monitoring as required
- Be the first point of contact for the patient

SPECIALISED MULTI-DISCIPLINARY TEAMS

Supporting the care manager and the coordination centre will be hospital based specialised multi-disciplinary teams. These will assess and treat people who require specialist input, for instance older people with complex needs or people who have had a stroke. These services will link together to provide the 'backbone' to integrate care around people as their needs become more complex.

Underpinning the model is the use of one assessment process and one set of assessment and care planning tools for use across all services.

We hope to have much of this in place by July 2005.

Under our proposal, Margaret's story 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.



**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

OUR PROPOSAL

We need to change the way we do things. At the moment we give care to people based on the service that they 'fit into', but we need to give care based on peoples' need. To do this we require a new community focussed approach to integrating home, community, primary and specialist services. We want to ensure that people get help before problems occur and make sure that the care they get is coordinated properly. We believe these changes will mean people have a better experience of services and better health as a result. This booklet is a small summary of our proposal.

FIND OUT MORE & HAVE YOUR SAY

We want to know what you think about this proposal. To find out more log onto www.ccdhb.org.nz and read the proposal in full, call Andrew Downes on 04 803 1115 or email Andrew.Downes@ccdhb.org.nz. We are also holding public forums to get people's views. To find out about these call Peter Barton on 04 918 1141.