
Proposal for the Integration of Home, Community, Primary and Specialist Services in the Capital and Coast District

Report on Submissions

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Prepared by

ACQUMEN
quality solutions

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Executive Summary

From June to August 2004 Capital and Coast District Health Board (C&C DHB) undertook a public consultation on its proposal for the 'Integration of Home, Community, Primary and Specialist Services in Capital & Coast District'. The consultation period was from 15 June 2004 to 28 July 2004. This report is a summary of submissions received and meeting notes taken during the consultation period. There were 50 submissions received representing 186 people as well as a series of nine presentations and public meetings/hui/fono which were attended by approximately 165 people.

Overall the response to the proposal was very positive with all respondents agreeing with the proposed vision, most agreeing the model would improve services and that the approach will achieve the objectives. Many congratulated C&CDHB on its approach.

Overall service users were highly supportive of the proposal. Dissatisfaction with current services and their ability to work effectively with older Maori people and their whanau was a significant factor in Maori support for change.

One family with members who describe themselves as having complex needs commented that;

'...the proposal offers management that we have been encouraged to assume as our personal responsibility, albeit assisted by caring service providers at both a clinical and community health level.'

A common comment was that the consultation document was high level. Respondents wondered about the detail, how the concept would be implemented, how the interfaces between services would be managed and how the integrated services would develop.

Most difference in views occurred in relation to the location of care managers, although the majority of respondents did agree they should be based in Primary Health Organisations (PHOs). This is a new role and many respondents raised queries on functions and responsibilities, relationship with other roles and services, how it would be managed and standards of service maintained.

As one group commented the most important questions appear not to be where the care managers are based but rather;

- What training will they receive?
- How much budget will they hold?
- How well supported will they be by other staff, across the spectrum of services?
- What supervision will they have?
- What workforce development will be in place for the development of these positions?
- What interface will they have with the ACC case managers?

There were a range of views on what the next steps should be, including a gradual implementation process beginning with piloting parts of the model. Irrespective of how the model is implemented there is agreement that there should be an emphasis on maintaining and building the small and specialised older people workforce.

Approach

The consultation period was from 15 June 2004 to 28 July 2004 and late submissions were accepted. As part of the process a discussion document 'Integration of Home, Community, Primary and Specialist Services in Capital & Coast District' was developed and distributed to stakeholders by direct mail and by placing it on the C&C DHB website.

The proposal was also presented at a series of nine presentations and public meetings/hui/fono.

- 9 June, Māori Partnership Board Meeting
- 23 June, Joint DSAC/CAPHAC Forum
- 15 July, Kapiti Coast
- 19 July, Porirua
- 20 July, Wellington
- 21 July, Pacific Health Group - Newtown
- 26 July, Māori Consultation Hui
- 29 July, Vaiola Trust and Pacific Health Service Porirua
- 5 August, Pacific Women's Action Group

Apart from the DSAC/CAPHAC Public Forum on 23 June, the format for each gathering was similar and began with a presentation from the CEO/Project Team (20-30 minutes) followed by an open question and answer session.

Notes were taken at each public meeting/hui/fono and included in the analysis of submissions.

The report is a summary of submissions received and meeting notes taken during the consultation period.

Submissions Received

The total number of submissions received was 50.

Respondents were asked to describe themselves, the type of organisation they were responding on behalf of, or the organisation they work for¹.

C&CDHB	18
Non-government organization (including PHOs)	17
Central government	2
Service user	6
Private citizen	4
Other – local agency or interest group	13
Total	50

Respondents were asked to identify their ethnicity.

Maori	3
NZ European	21

¹ Note that some submissions recorded more than one type of organisation, particularly those that were compiled by more than one person.

Pacific	2
Other	4
Total	31

29 respondents did not identify their ethnicity.

The number of people who contributed to the submissions received was 186. Of this number 58 (31%) contributors work for C&CDHB and 81 (43%) work for PHOs.

Responses to Questions

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

Around 50% of respondents considered there were services, funding or groups or people that had not been mentioned in the discussion document.

The most frequent suggestions were;

- People under 65 with complex disability and health needs or *'those deemed like in age and interest'*
- ACC including the interface with ACC case managers
- Refugee and migrant communities and services, including interpreter services
- Mental health, including links with child and youth services and Addiction services
- Pre- assessment clinics – identifying needs prior to surgery/ treatment
- Convalescent and intermediate care
- People with progressive neurological disability and organic disorders such as Huntingtons Disease and Wilsons Disease, particularly care management
- People with an intellectual disability

Other suggested inclusions identified by 1 or 2 respondents were;

- Services provided by family members – *'those providing should be financially supported'*
- WINZ
- Graduates – people with enduring mental illness and psych-social needs
- Palliative care
- People not enrolled in PHOs or without a GP
- People with non-medical needs e.g. lonely older people
- Equipment for people with obesity. This is not recognised as a disability and personal health does not accept responsibility
- Crisis intervention service
- Transport
- Free Ambulance Service being used to cover the gaps e.g. medication mishaps post discharge

Other respondents sort further clarification on the criteria for services.

- *'How high is the threshold for chronic illness?'*
- *'Where do the needs of Maori and Pacific adults who don't reach 65 years of age but develop health care fit in?'*
- 18+ with chronic illness may be a too high threshold for Maori and pacific people to meet (greater need present)
- *'Who will pick up the 16-18 age group?' and 'why should they be excluded from the benefits of this model and combining the funding 'buckets'?''*

Those who commented on people aged 16 – 18 years did not agree that they should sit within this model but want clarity on where their services should be accessed. Some respondents suggested the need for consistency throughout C&C DHB as to where child health ends and adult health begins.

Several respondents requested clarification on the relationship between the proposal and other services including the Cancer Society and field workers for Asthma Society and the Epilepsy Association.

Many noted the importance of addressing wider inter-sectoral issues associated with positive ageing and disability issues such as income, housing, transport etc. This was qualified by acknowledging that the proposed model needed to be established before it could be extended to include other sectors.

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

Overall it was considered the consultation paper provided a good summary of problems.

Many respondents elaborated upon or added to the list of problems including;

- Lack of integration with psychiatric services – it has to be a *'one stop shop'*
- *'Currently consumers have to fit the service model available rather than how do we meet this person's need'*
- *'Disparity is the biggest issue...often due to culture or financial restraints'*
- Inequity of access to funding
- *'There is often the problem of services being [available] but no clear pathway for the consumer to be able to receive services'*
- *'Lack of coordination and ongoing accessibility issues are central to some of the problems experienced by Pacific people'*
- *'Transport – access issues for Kapiti residents'*
- *'Lack of knowledge and understanding of Maori health and wellness; lack of acknowledgement of the role of whanau have in ongoing care and support; lack of knowledge and training of staff working with Maori'*
- *'Gate keeping information and entitlements and use of terms such as "we are being very generous"'*
- *'Inability to have the whole whanau involved in decision making and care support'*
- *'Assumptions rather than assessment of whanau involvement in care'*
- *'Inappropriate use of Maori liaison – bought in when a complaint was made'*
- *'Inability to describe who does what, and who is responsible for which piece of the puzzle, resulting in frustration for whanau trying to navigate the system'*
- *'The problems identified focus on the access pathways to services and the lack of communication between these...rather than the actual provision of services. Hence a large part of the system is not included e.g. care shortages, payment systems, information systems'*
- *'Good agencies and volunteers need to be recognised and respected. Many were set up to [address] gaps in services'*
- The need to look at why people are moving to resthome and hospital care.
'Addressing some of the gaps such as night care at home, sheltered accommodation options, daycare'
- *A 'shortfall of skilled staff passionate enough to work with older people'*
- *'This is only half the equation. If C&C DHB wants to really move services from the acute to primary health care sector...Presbyterian Support Central believes the DHB would need to look at service delivery issues...including care training, recruitment and retention, travel and the price to providers'*

Three PHOs' commented that this is *'timely given the growth in service development in primary care, which is beginning to experience some of the identified problems in secondary and community health.'*

Capital Coast Rehab commented that they don't experience the problems identified as they *'utilise the key worker model'*.

One group said that there would still be times where assessment would need to be duplicated. *'A clinician will still need to reassess information that has been given in order to make relevant clinical decisions in the time and place that they are seeing the patient'*.

One respondent commented that *'Capital Support does a very good job in their NASC role however two things have diminished their ability to make clinical judgements in assessment; firstly physical distance between Capital Support and AT&R and secondly the fact that their role does not have an acknowledged clinical basis which is maintained overtime through training. We will get better outcomes from the MDS if care managers bring a clinical knowledge to the assessment process.'*

A small number of respondents commented that the proposed system would have problems similar to those that occur now.

3. Do you agree with the vision we are trying to achieve? Do you agree the model we're proposing will improve services?

All those who responded to this question agree with the vision.

'Absolutely! Yes I support the idea that clients shouldn't have to repeat their stories over and over again to different service providers, nor should they have to wait long for their care to be co-ordinated.'

'The holistic focus of the consultation document reflects how women largely view their lives and this is even more so for Maori women...creating one point of entry for everyone will go a long way towards many women's voiced concerns.'

'... the proposal offers management that we [as service users] have been encouraged to assume as our personal responsibility, albeit assisted by caring service providers at both a clinical and community health level.'

'Agree with the vision and what the DHB is trying to achieve, and are aware that fulfilling this vision will be a large task. We [PHOs] strongly support models that are based on:

- *early intervention*
- *continuum of care*
- *seamless care for the patient/consumer and their family/whanau.*

We also strongly recommend the DHB consider including reducing health inequalities as part of the vision for this service, particularly for Maori, Pacific, refugee and migrant populations. This should be fundamental, and an integrated part of this service.'

One group of respondents commented that *'the vision is something that all services are trying currently to achieve'*.

One respondent suggested changes to the vision.

*'People...should receive **highly skilled**, coordinated and accessible..'*

'Home, community etc services will be integrated through a common philosophy, and the shared goal to deliver best care to the consumer...'

Many respondents commented on issues that may emerge with the development and implementation of the model that may need to be managed.

Comments included;

- *'There are marked differences between the PHO's philosophically, financially and resources, and population bases. It may be unrealistic to expect them all to act with your vision at heart!'*
- *'There is not clarity about the need for a culture change of the underlying philosophy that underpins the vision...changing the structure does not change the culture'*
- *'This system will only be as good as all the information being forwarded and collated in one central place so everyone needs to do their part...then there will need to be appropriate people to implement what was envisaged...training will be needed and this will take time. But full marks for the idea!'*
- *'There needs to be strong linkages to Care Plus and primary care programmes. Many of the patients who will be accessing integrated care services will have care plans developed at a primary care level'*
- *'The key to success will be implementation. As well as resourcing (that is ensuring that coordinators have a case load that allows them to effectively fulfil the objectives) a critical determinant of success will be ensuring the buy-in of all stakeholders'*
- *'It is assumed that the DHB proposes to remove current prioritisation-based access criteria and move to an early intervention model. We strongly support this change in focus but...see volumes will increase and this will require additional funding'*
- *'Further clarification is sought on what the prioritisation process will be'*
- *'For whanau Maori a key issues in the ability to stay in the home environment...long term care is not a preferred option and one we actively avoid...we should design generic components with Maori specific options'*

One group made the comment that the objectives in the consultation document are very broad and that they would like to see more specific objectives that can be measured. One of the examples they gave was how would the objective that people will be more satisfied with the care they receive actually be measured?

One person commented that improvements could be made in the existing system and queried the benefits of the new model.

'Immediate improvements could be achieved with an integrated clinical record in which all health professionals wrote...so you have an immediate timeline for any intervention. Creating new structures to achieve the above will be costly and likely to duplicate...PHOs are creating another layer for people to remember.'

Another person asked if the proposal went far enough.

'Objectives should include a seamless service which eliminates waiting for essential help and services. 'Not having to wait as long...' is not good enough.'

Another respondent wrote that the *'sense of urgency for improvements as felt in the community is not conveyed.'*

4. Do you agree the model we're proposing will improve services?

Most contributors who responded to this questions thought the model would improve services.

'The direction of this initiative is clearly designed to dispense with the old model which was fraught with restrictions and eligibility criteria to one where the circumstances of each situation can potentially be much more effectively addressed.'

Many qualified their response by saying that the model would only be successful if there were sufficient resources. The resources identified included cars, the range and quality of services available particularly home based support, the number of clinicians and care managers. Other staffing related comments included remuneration, good provision of education and supervision.

'Providing there are sufficient staff that have consistent knowledge of the local environment – family, community and services available'

A small number of respondents also qualified their response by saying the proposal has a medical focus and that this can take the focus away from community health and wellness.

For Maori improvements will be made if *'staff are trained and have knowledge of working with whanau Maori, specific assessment tools designed for Maori clients not adapted from existing tools and administered by untrained staff, communication, full disclosure of services, options, entitlements to enable appropriate whanau support and involvement'*

Participants at Pacific forums emphasised that improvements will only be made if Pacific people are involved at all levels of the model including planning and provision, care management and coordination.

A number of implementation questions were raised.

- *'Will the care manager be able to refer to specialists after assessing patients or will this still have to go through the GP?'*
- *Will the introduction of care managers 'further reduce the number of people hands on...i.e. more people involved in coordinating rather than direct service provision?'*
- *'If the MDS picks up lots of patients/ people with high-risk nutrition issues how will this be managed? Will advice be given by non-dieticians or through funding for community based-dieticians?'*

Respondents from PHO's and home based support providers commented on the need to ensure the role of care managers and the care coordination service is clear, including how this interfaces with the care planning and coordination by primary care teams and service providers. This is required to avoid duplication and ensure the plans are aligned. For home based support providers there is also the need to match staff and provide a safe work environment.

One person agreed that the model will improve services but considered a *'major problem is that the patient enters the new systems without proper diagnosis. Diagnosis is the fundamental basis of appropriate, effective and efficient delivery of care'*.

Several groups including staff working in PHOs and C&C DHB commented that the document did not make it clear that although there were benefits in greater flexibility in the use and allocation of funding, prioritisation of the community's needs would still be required. Indeed, it is likely that this model will increase the challenges of prioritisation as

more needs and opportunities for early intervention are likely to be identified. Further clarification on the prioritisation process was requested.

A small number of respondents disagreed with the model.

'We feel it is out of step with current rehabilitation practice. There is still a sense of the patient as a passive recipient where community services must adopt a collaborative approach between stakeholders and service providers. With two community teams you will still get referrals back and forth as they do now.'

4.1 What other changes or solutions do you suggest?

Suggestions included;

- Address issues related to home based support services e.g. recruitment and retention issues, level and nature of staff skills
- *'Capital Coast Rehab and Therapies combined to provide one service where staff can work across all diagnosis / age groups'*
- *'There could be economy of scale, better retention of occupational therapists and better return on...skills if a central unit/ service could handle the non-clinical part of Enable applications for complex equipment and for housing modification'*
- *'Is it possible that the proposed Stroke Services might be managed by a PHO for the Board?'*
- *'A good start but we would like to see the model grow intersectorally over time and have more of a holistic focus'*
- Increase focus on support for carers/ whanau
- Address people being discharged to or moving to a different DHB
- Develop guidelines for referral

Several groups commented that the proposal provided insufficient detail on the information systems, and that this would need to be addressed to enable sharing and transfer of client information between PHO's, hospital and other services.

'One of the concerns that we have is that if a person who fits this criterion is admitted to the inpatient area or Emergency Department that the care manager will have the information that is required to integrate their care. If the electronic systems are not integrated then there will still be difficulty in getting timely access to that information. Nothing will have changed in terms of more timely access to information; the only change will be a different knowledge holder.'

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

There were different views in whether seeking proposals was the best option for ensuring the best mix of providers and flexibility of services. Overall most respondents saw there were advantages and disadvantages and agreed that what was more important was the criteria used to assess provider capability with suggestions for this including previous experience, current relationships with community and specialist services, quality systems, administration and management ability and costs.

One respondent said that the focus should be on ensuring *'adequately trained, skilled, sensitive and empathetic people are chosen.'*

A sample of the advantages of seeking proposals identified included;

- *'RFP processes stimulates thought and development ideas'*

- Potential to foster culturally based services
- Will require service specifications to be very clear about skills, expertise and outcome requirements
- Encourages creativity and flexibility
- An opportunity to consider options and address gaps
- Transparent

A sample of the disadvantages of seeking proposals identified included;

- *'There are some negative aspects to a RFP process e.g. stretching the resources of community based organizations. We would prefer a mix of RFP and allocation/ consultative models'*
- *'...could end up with clinicians or services becoming very territorial'*
- *'...implications for splitting the fragile workforce'*
- *'Will this get consistency in service?'*
- *'...having a multiplicity of providers adds to the complexity of management of the total care system and the packages the service users have to cope with.'*

Several groups considered that a selection process was not required as the DHB was the most suitable provider.

- *'We feel that the expertise to provide this service is most likely within the DHB. If this service were to be provided by [a different] organisation; how would the organisation be monitored? How would they ensure their staff have the required skills? How will the interfaces with numerous services be developed and maintained? How will access to DHB based IS systems like Allegra and Clinical Records be provided? Access to these systems is essential.'*
- *'Certainly if run by a government body justice, fairness and equity is more transparent'*

A majority PHO view was that if the DHB decides to contract with them for the main part of the service then they work together to develop the service model. *'We consider this would be the most beneficial and efficient use of time and ensures that ideas can be shared and discussed in an open and transparent manner.'*

Many respondents thought there could be value in tendering for the Care Coordination Service. This would ensure a transparent process was followed and any real or perceived conflicts of interests could be identified and resolved. An example of concerns about possible conflicts of interests was provided by one group of respondents who considered *'the care coordination service should stay with the DHB so that there can be clear differentiation between service provision and assessment/ funding options.'*

Several respondents commented on the importance and value of involving consumers in the RFP process. *'A broader picture is obtained if those who have personal experience, family or friends' are involved.*

The Vaiola Trust commented that due to limited investment in Pacific providers, the small size of providers and workforce development issues that contestable processes are difficult for them as *'it is not a level playing field'*.

Several respondents raised issues related to the delivery of home-based support.

- *'There have been gaps. I have clients in the present system that have had daily help funded but agencies have not been able to provide weekend carers thus the service is not delivered'*
- *'Improved training for caregivers is essential'*

- *'We are aware there are no standards of care for providers...therefore it would be difficult to assess proposals...and this should not be based on cost alone'*

6. Do you agree that the Care Managers should be employed by PHOs and based with primary care providers?

Although this question prompted the most significant variation in views, on balance the proposal was agreed to by a small majority of respondents. The reasons most often given for agreeing with the proposal included that the goals of increasing early detection and intervention, reaching Maori, refugees and other groups were most likely to be achieved if care managers are employed by PHOs and based with primary care providers.

Other comments included;

- *'Ensures neutrality, consistency, clearing defined pathways'*
- *'This is critical to ensuring the coordination happens at all levels and that primary care have some influence and ownership. Identification of those 'at risk' happens best in this setting'*
- Makes one person responsible

Several respondents commented that should PHOs employ care managers they would require specific guidelines on roles and responsibility; clear recruitment criteria and 'scope of power'. Others raised operational questions and asked how practice standards could be monitored.

'Is there an expectation that care managers will require an annual practicing certificate...if so I believe the implications of the various Board's interpretations about how individuals who are not specifically practicing in their original area can demonstrate ongoing competence. There may be a requirement for a limited amount of clinical work in their areas.'

One respondent commented that if care managers have responsibility for allocating service then there is a risk of variation between agencies and inequities between service users.

Some respondents commented on the timing of the proposal.

- Further definition of the role of PHOs is required first
- *'PHOs are not yet well enough established to employ and manage this process [though] we agree care managers should be in the community'*

Several respondents commented on care manager support needs during the development of the service model.

- *'[Care managers] are at the same time the most important part of the proposal and the part associated with the biggest risks of failure...suggestions to combat these problems would be try and appoint the best people available; at least for the first 12-18 months put in lots of collegial and medical specialist support/ input; consider routine medical paper review of all referrals; don't put the case managers in primary care until they are substantially trained up (12-18 months), even though in the long run it makes sense to have some case managers within PHOs...'*
- *'Research identifies isolation and alienation of workers as an issue especially when operating in a new model. I suspect that a small team approach is more relevant than where they are based'*

- *'Our concern is to ensure there is good training and support for care managers. It seems to be a whole new area of health training which builds on the range of specialist nursing and healthcare already in place'*

One group responded that where care managers are based is not the most important questions are:

- What training would they receive?
- How much budget would they hold?
- How well supported would they be by other staff, across the spectrum of services?
- What supervision would they have?
- What workforce development would be in place for the development of these positions (which are vital for the success of the delivery of this model of care/access)
- What interface would they have with the ACC case managers? (as a significant number of elderly people have ACC case managers as well as primary health care needs)

The reasons most often given by those who considered care managers should not be employed by PHOs related to consistency of assessment, management and service quality, particularly if multiple PHOs are involved.

Comments included;

- *'There is too much variance between the operations of PHO's to maintain equity of service'*
- *'Community governance of PHOs is not a reality in some large PHOs, meaning that medical practitioners and managers generally control the business with some input for other health service providers and a few service users' representatives'*
- *'While some Pacific providers feel they have good input to PHO's, others feel that Pacific needs are not be adequately addressed and that their influence is insignificant'*
- Basing them at C&CDHB would;
 - give them credibility, improve communication between the care manager and community teams, and ensure mutual support
 - mean the service provided *'was not dependent on individual PHO's agendas or ethics'*
 - *'give more accountability and consistency to the role'*
- *'I don't agree that the care manager role sits on its own...some care managers should sit in the Specialist MDTs and some in the community based care...skills and knowledge shared are important'*
- *'PHO's.... are not set up to take allied health professionals and are unlikely to be for some time...to ensure patients receive equity of allied health services, cover for leave and vacancies, ongoing education and support the allied health should remain with the DHB'*

Some respondents did suggest other options for locating care managers including;

- Care managers should be joint PHO/ DHB positions
- Care Managers should be employed by the DHB but located in PHO offices
- Care managers should be together in a standalone services. One respondent said this would ensure impartial services, not influenced by bigger PHO's or those with high needs.
- Care managers should be with the co-ordination centre – this would reduce fragmentation and avoid the possibility of both needing to communicate with the client
- Pilot several options and see which works best

Pacific providers strongly support community-based models of care so considered Pacific providers were best placed to meet the needs of Pacific people. They put forward the following alternatives for consideration.

- Pacific care managers based in Pacific Support Service. This would involve enhancing the role of Pacific Support Service in the hospital to include care management responsibilities
- Pacific care managers in Pacific primary care providers
- Ensure the care coordination centre has culturally competent Pacific staff

One respondent thought care managers should be based in the service best positioned to meet the client group needs and suggested;

- Maori and Pacific people based in PHOs. Reasons offered include that PHOs employ or are already affiliated to professionals who will meet many (not all) of the needs identified e.g. diabetes
- Older clients requiring early intervention seen by care managers based in PHOs
- Older clients with complex needs require a Specialist AT&R team. Social Workers and RNs in these teams should deliver the care management function in conjunction with their clinical role.

Decisions on where they are based should be made after consideration of a set of principles. Suggested principles were;

- What are the general needs of the particular client group?
- What knowledge and skill base is required to meet that need?
- How would the care manager initially develop and then continually grow that skill base?
- To who is the care manager most likely to be making referrals for that client group and how can the care manager operate as a team with those people?
- What additional functions might the care manager deliver other than just completing MDSs i.e. other social work activities or community development in a PHO?

'There is no doubt that regardless of where the care manager role sits, s/he will need to have good relationships with providers across the continuum. But I think that the key question will be 'to whom should they return at the end of the day in order to constantly develop their knowledge and skill base on health/social issues relating to their particular client group i.e. Maori /Pacific /80years+. The other question is 'with whom do they need to have the closest personal relationships in order to facilitate referral flow and new learning'.

6.1 Do you agree with the role and how it is defined?

While overall respondents did see the value of this new role, many respondents commented that there was not enough detail in the proposal and raised issues on the scope, functions and responsibilities of the role.

Two groups of respondents commented on the fit between care managers clinical role and allocating resources.

'The mix of roles within the case manager position...would place the person in a difficult position of having to allocate resources and implement the care plan. If there is no agreement between two parts of the integrated system where would the case manager go in order to get support and resolution for this?'

'We recommend care managers be termed care coordinators as...this more accurately defines their role. It also emphasises care 'coordination' of services rather than active

care 'management'. This could be confused with clinical staff who provide care...these people won't be 'doing the caring' so people need to be given the right notion at the start.'

Further clarification on the boundary of the care manager role and its relationship with other services was requested and suggestions included;

- *'We believe that this position would need to be backed by specialist medical input in order to ensure that there is continuous quality improvement of the type of intervention and care planning that has occurred'*
- *'Reference to the care manager picking up 'early warning signs' is not clear...Early warning signs, prevention, early intervention and appropriate referral are the role of the primary care team'*

A sample of other comments made include;

- *Care managers must have a reasonable workload. Will need to be able to attract suitable people so need formal qualifications with NZQA or School of Nursing, defined career paths'*
- *Are 30 care managers sufficient for the population base? 'Caseload numbers definitely need to be identified with additional weighting given to more complex cases'*
- *'Who would monitor standards of practice?'*
- *Care managers need adequate supervision and training*
- *Trained to develop assessments of a consistently good quality that meets the Guidelines for Assessment Processes for Older People.*

One group noted that there was little detail on the coordination centre in the proposal yet *'this is a highly skilled role'* requiring a high level of knowledge of community and clinical services.

Capital Coast Rehab do not consider that the care manager role is required and that components of services that effectively address many of the concerns detailed in the proposal should be incorporated into any new service structure. Their submission provides detail of the clinical key worker role, which has proved effective.

'A clinical keyworker is assigned to every participant who is accepted into the service maintaining a consistent point of contact and offering coordination and advocacy...liaises with the MDT, between other service providers and primary health providers.'

7. Do you think the suggested approach to change will achieve the objectives of this proposal?

Most respondents considered the suggested approach would achieve the objectives of this proposal. Some of the comments included;

- *'Streamlining the process will work in favour of the clients/ end users'*
- *'The approach is bold and innovative and I applaud C&CDHB for the proposal'*
- *'We wholeheartedly agree with the principles...and request these principles are upheld continuously throughout the programme of change'*
- *'As PHO's have streamlined primary care and access to services, this will enhance the gains with the addition of home care'*
- *'It will be important to include Maori health experts in the development and design of the service'*
- *'It is important to ensure that peoples' expectations are not raised only to dash them later. Funding must be secure and ongoing'*

Some respondents agreed with the approach but raised issues that should be addressed such as communication, professional liaison and interfaces, adequate resourcing, clarity of budget responsibly and adequate integrated information systems.

One group disagreed that the suggested approach will achieve the objectives.

'Our predominant reason for this is that we believe it will be difficult to resource. This proposal mentions that there would be 30-40 case managers who require significant experience, particularly in elderly care and care for those with multiple co-morbidities. Given that this is not an area... that has a lot of postgraduate education courses available and that there is difficulty in recruiting staff...this will be a difficult position to recruit to...without creating a drain from the therapeutic side of service provision. This is a major workforce development issue and we are not aware of any workforce development strategies that would address this issue.'

7.1 What other approaches would you suggest?

Some respondents raised issues they wanted further consideration given to.

- *There are many good things in the proposal but bureaucratic, cumbersome, expensive and poorly targeted care [will result] unless intervention and care is based on sound diagnostic and therapeutic basis'*
- Avoid therapists working in isolation
- *'Ongoing review of the functional performance of the patients should be included'*
- *'Possibility of remote specialist clinics, particularly for the elderly population with poly-pharmacy and co-morbidities. These clinics could be based in PHO's and be a specialist led clinic or a joint clinic.'*

8. Are there any additional comments you would like to make?

Many respondents made additional comments. These have been grouped below.

8.1 Specialist Services

Most of the comments related to the role and functions of specialist services in the model and its relationship with other services. The Ministry of Health commented that the respective roles of the care manager and Specialist MDT are not clear; a view shared by many others.

A sample of other comments includes;

- *'The term specialist team is quoted, without definition for example] in occupational therapy, a referral could occur for retraining under rehab, or specialist environmental modification or prescription. Each are specialist entity's within occupational therapy'*
- *'Staffing issues for the different areas of Older Persons, Rehab and Stroke would be difficult thus sharing resources across the three would be a big advantage'*
- The stroke team *'proposition offers an outmoded segregated servicing concept...and surely defeats the vision of integrated service provision'*. Several respondents shared this view.
- Referring to the Stroke Service *'this part of the document is rather weak...A solid starting point for planning these services exists within the 'Stroke Blueprint' developed by the ATR service'*
- *'We believe there is still a need for the liaison nurse role within AT&R multidisciplinary team in the new structure, to ensure the nursing roles of assessment, advocacy and therapeutic relationships are maintained'*

8.2 Relationships between services

Many queried the relationships between and the responsibilities of the different services and roles. They also urged that the development of referral guidelines and clinical pathways begin soon, and that those who will use these tools are engaged in their development.

One respondent commented that 'there should be clarity about the clinical responsibility for how the client is managed. Presumably each service involved in care holds the accountability for that aspect of care in which they are involved in delivery. But the responsibility associated with the coordination function, and for any adverse outcomes associated with coordination failures, is less clear. It may be helpful for such matters to be discussed.'

The Ministry commented on the Care Coordination Service and that *'it may not be desirable to have all clients funnelled through the care coordination service.... care managers based in PHOs, which would have a lot of advantage for continuity of care' could take referrals directly from the GP. 'The care coordination service could still be the repository of all care plans'.*

Another respondent commented that the model will only succeed if *'the coordination centre works and the information systems between all entities are able to logically integrate so all stakeholders have access to all relevant information in a structured and timely manner – from initial referrer to payment.'* Further information on how the relationship between the PHO, care manager and coordination service would work was requested.

8.3 Assessments

Many comments were made on the proposed assessment processes and below are a sample of these;

- *'I worry that the MDS will continue to exacerbate a current problem where the assessments are only at the level of activity limitation with some impairment, ignoring pathology, where it is possible that the opportunity exists to intervene successfully'*
- *'We have concerns about the quality of the initial assessment using the MDS tool, and how this assessment will be kept up to date as the client's needs change.... To what degree will the initial assessment determine which disciplines are involved, and will the process ensure that the assessment results in referral to the most appropriate health professionals?'*
- *'...how realistic is it for all PHOs and service providers to purchase the MDS tool...'*
- *'Age Concern Wellington is supportive of the principles and concept of this proposal. In fact it embraces the aim of the Guidelines for Assessment Process for Older People in a visionary way which, if implemented effectively, should really enable more people to age as well as possible'*
- *'Training in the MDS system must be sound....there is good evidence that untrained or insufficiently trained staff miss opportunities for reversibility that are so important'*
- *'All other health professionals involved need to be well schooled in the system in order to buy into it effectively...most importantly older people and their families and whanau need must be so informed that they feel they are experts in ageing well-being and feel enabled'*

Many respondents asked for more information on the MDS and the Ministry of Health noted that *'It will be some time before there is a decision made in whether the MDS will be adopted (in adapted form) in NZ.'*

8.4 Community Services

Threaded through the responses to many of the questions, comments were made on the capacity of community services to deliver the necessary supports. A sample of these included;

- *'There are serious long-standing and increasingly urgent workforce issues related to this range of health services...I would like to see that they are addressed as part of the development and integrations of the services discussed in this proposal.'*
- *'As long as the situation exists where people are unable to receive either the amount or the quality of home support they are assessed as needing outcomes will be jeopardised'*
- *'Expectation and demands will increase; funding streams will need to be flexible; relationships and collaboration are crucial'*
- *'Change to the system needs to recognise existing potential in existing providers before looking to duplicate or redirect aspects of service delivery' (referring to home based support)*

On a different but related theme, one person commented on the need for care management and coordination to be responsive to community needs.

'Flexible care provision should also be reflected in flexible assessment/ case management etc. People need to not only be able to contact your service but also to access your service equally on the weekends and public holidays too. Their needs do not reduce at the weekends'

8.5 Maori

Maori respondents strongly supported the proposal and also raised issues about the capacity of all services to meet their needs.

'The fundamental issue is cultural safety, the ability of agencies to work with whanau in an appropriate and safe manner...'

'Services for the elderly must be cognisant of Maori expectations of being cared for at home, as well as the significant obligation that whanau have to make sure that this happens'

8.6 Pacific

Pacific contributors commented on the need for input and greater participation from Pacific people in both the planning and delivery of services.

8.7 Service gaps and linkages

Some respondents highlighted service gaps or linkages;

- *'At Porirua CAB we see a real need for day care facilities'*
- Health promotion
- *'We are hopeful that the Palliative Care review will interface with the new model of care and therefore provide more clarity for our service providers and user groups.'*
- *'An emphasis on preventative health systems, exercise and companionship'*
- *'Not clear to what extent psychiatry of old age are included in the model'*
- Need to clarify the interface with ACC

Based on personal experience two respondents were adamant that in the future the scope of services provided from the model should not include specialist oncology nursing and services.

8.8 Next steps

Many respondents commented on the next steps with some suggesting that components of the model are piloted first to ensure they work before being widely introduced.

Other comments included;

- *‘Best to stage the approach and implement over five years’*
- *‘Go slowly and carefully’*
- *‘...pilot a more integrated management of home community, primary and specialist services in one medium sized PHO which is proactive in its approach to the care of the relevant population within its membership’*
- *‘Slow and steady approach; small changes at a time; monitor staff and employee attitudes; don’t copy cat UK/USA models just because evidence based; be bold and consult widely and develop a service suitable for the NZ culture and needs.’*

A different view was put forward.

‘Unforeseen consequences of gradual implementation [can occur]...if implementation of this proposal is not reasonably well timed and synchronised. If access for individuals or groups of older people becomes delayed the outcomes may not be as good as required and the process then in danger of disrepute. Then there might be disillusionment both among the public and health professionals.’

‘Nothing has been said about the cost of this model – how it compares with the current approach and, assuming, it will cost more, where the money is to come from...in the absence of [this] Age Concern Wellington has concerns regarding the District Health Board’s process from here. Will there be an opportunity for further consultation when more detail is known?’

There was agreement that ensuring processes and interfaces are clear, managing risks and maintaining continuity of services was critical. One group suggested a help line be put in place.

8.9 A final comment

‘Very pleased with the process C&CDHB have undertaken to share this proposal with the public, providers etc and encourage continued engagement on developments.’