



Developing Community Nursing and Allied Health

~ An Overview ~

19 March 2007

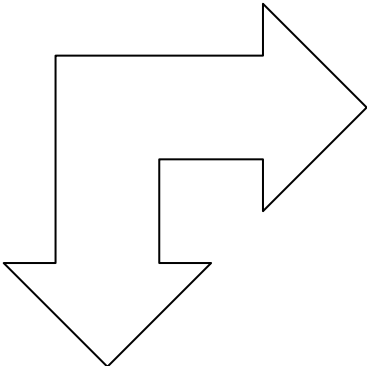
Background

- Context - Health of Older People Strategy 2002
- Response 2003/04 – ‘Integrated Home and Community Care’ programme, developed from:
 - An Advisory Group on services for older people established July 2003 - included consumers, interest groups, providers and health professionals
 - A project group on specialised services commenced at the same time - made up of health professionals from hospital and primary care
- Both groups identified the same fundamental problems - and had broad consensus on solutions

Home and Community Care, quick re-cap...

MoH Policy:
Older Person's strategy
Devolution of DSS funding

CCDHB:
Service reviews



Many problems:

Confusion/dissatisfaction:

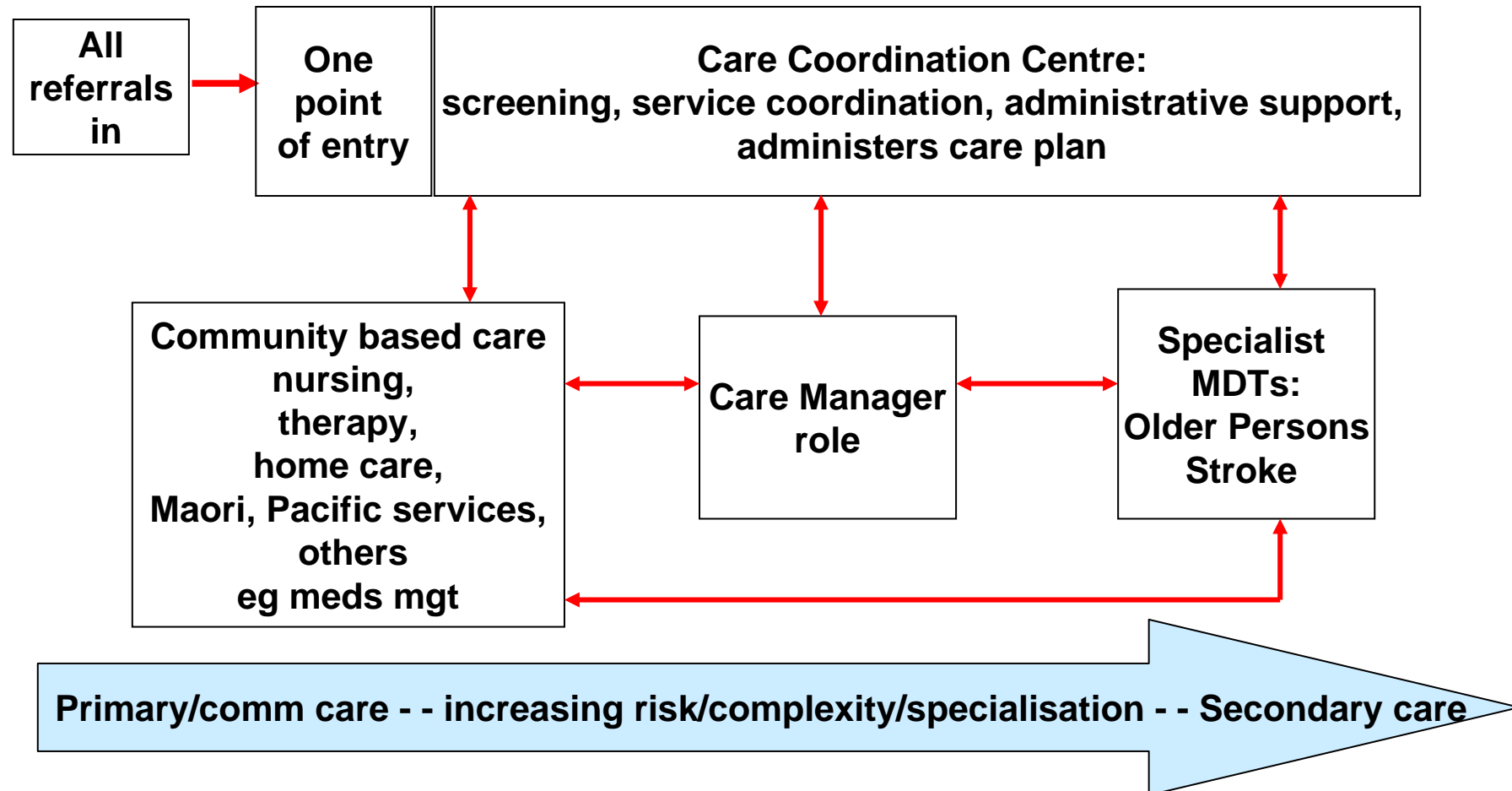
Too many referral points
Too many assessments
Passed between pillar
and post
System is inflexible
Inappropriate services

Analysis of 50+
Age group and service use:

Complex group (900)
30% of in-pt admissions

Others 9000 use of
community services
1/3 high use (multiple services)

Overall Model



Our response & broad aims

Response:

Integrated Care programme:

CCC

Care Managers

Interrai

Packages of care

Older person service

Stroke service

Others....

**Main aims for that group
across services:**

**Control admission
to residential care by 5%**

**Control acute
admission by 5%
(those in complex group)**

**Make system more accessible,
flexible and less
confusion/duplication
eg reduce re-assessments**

**Improve satisfaction with
services for
both consumer and carer**

Where are we up to?

- Majority of **infrastructure** of model in place
 - CCC, Care Managers, new model for delivery of home & community services (package approach), linkages to primary care
 - More preventative in focus/integrating with primary care
- Still transitioning into new model from previous
 - build up of package approach
 - Still areas to address eg aspects of palliative care, continued refinement of processes
- Other services accessible through the model
- Need to design and plan next phase

Progress to date

Project	Achieved
Care Coordination Centre/Care managers	Established Care managers aligned with PHOs (Maori/Pacific/ACC)
Interrai - pilot then progressive roll out (case finding trial, national business case)	Continue to progress PCCS - current Mary Potter - current OPS/ATR – July (ish) Primary care/community
Palliative Care review	Many changes
Older Persons service	Rehab/community - Acute – model defined new clinical leader
Stroke service	Rehab – in place Acute –so very very close
Packages of Care	Established Need to develop comprehensiveness/processes

Palliative care, achieved..

- CCC operates as Single Point of Entry for all Mary Potter Hospice Referrals
- Mary Potter Care Coordinators:
 - Act as ‘care managers’/interrai
- The CCC coordinates home nursing services at the very end of life (previously contracted to Cancer Service)
- These services are available to people with diagnoses other than cancer

Palliative care, achieved..

- Increased funding provided to Hospital Palliative Care Service to enable the team to expand
- 10 Nurses working in Aged Residential Care in C&C DHB received scholarships for the Postgraduate Gerontology Course (Victoria School of Nursing and Midwifery) – palliative care a key component of the course
- Palliative Assessment & Advice Service & Palliative Education & Liaison role –develop with MPH

Other linked initiatives

- PHOs - pharmacist facilitator roles
- Pharmacies - medication use review/adherence support
- Supporting carer's – change from crisis/re-active to proactive earlier intervention
 - Packages
 - Develop approaches and range of use (not just plain old inflexible respite)
 - Carer assessment
- Equipment
- ACC

Evaluation of programme

- Several strands to evaluation
- Independent evaluation at 2 years

Principles

- Increase focus on chronic care management and prevention
- Services to be close to the communities they serve
- Primary & community care viewed as first and main point of contact providing a more comprehensive range of services
- Grow and extend home and community services
- Develop workforce/roles, especially community support worker
- 'In-reach' rather than out reach
- Comprehensive assessment at a unique point of entry
- Integrate funding and service provision more
- Achieve the appropriate balance between community and DHB service provision

Future Givens

- Focus more on chronic care
- CCC oversight
- Package of care approach; type, extent and mix to be developed
- Integration with primary care/after hours
- Workforce development required, esp. community support worker
- Careful consideration of some services
- Ensure quality and flexibility

Information available on C&CDHB website

<http://www.ccdhb.org.nz/planning/homecommunity>