



age *WELL*

Integrated Care Plan for the Health of Older People

2004 - 2010

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1.0 Executive Summary

This Integrated Continuum of Care Plan, *ageWELL*, sets out the direction for services for older people in Taranaki. The plan covers the next six years, that is, until 2010. It includes service development priorities, an action plan for achievement of these.

The plan proposes developing sustainable health systems for older people. The vision is to co-ordinate health and other related services to enable older people/kaumatua to remain healthy and active in their communities. The plan has a number of goals including:

- Enhancing the role of the primary care team for early intervention and case management
- One contact person in a service co-ordination role for the older person
- One assessment service that, with Information system development and co-operation across providers, will reduce the number of assessments and “re-telling the same story”.

This plan also suggests the concept of enhancing the emergent networks and refining those, so that information is shared for the benefit of older people.

Information would be shared across the sector, across providers and to the public. Obviously different types of information belong in each area, but for the older person community there is a growing need for widespread information about services available – in particular communities. These networks are merging now and can be further enhanced.

ageWELL is about identifying needs and matching those needs with available resources. To provide the best match of needs and resources, there should be appropriate assessment of needs. A one stop, single entry point and multi-disciplinary assessment service is integral to the plan. The assessment team is named Taranaki Older Person Assessment Team (“TOPAT”).

2.0 TDHB Commitment to the Treaty of Waitangi

Taranaki District Health Board (TDHB) recognises the special relationship of Maori with the Crown. TDHB is committed to satisfying its obligation to recognise and respect the principles of the Treaty of Waitangi within the framework of the New Zealand Public Health and Disability Act 2000. TDHB will ensure that publicly funded health and disability services are responsive to the needs of Maori and will enable greater Maori participation at all levels of the health and disability sector.

TDHB is committed to:

- o Being honest and open in its consultation and engagement with Maori on health matters.
- o The development, implementation and use of services and procedures that is responsive to the cultural expectations of Maori.
- o Fostering the development of Maori capacity to enable Maori to participate in and contribute to strategies for Maori health improvement.

3.0 Background

The Health of Older People Strategy and plan will guide development of the primary and secondary services for older people to ensure an inclusive, ageing in place effective provision of services to 2010.

The continuum of care plan is developed from a number of strategies and policies at national and local level as well as the district strategic plan for the Taranaki District Health Board.

3.1 How Was the Plan Developed?

The plan is based on what is known about current services, current providers, identified needs, our particular population and information we have about future needs. It has been developed by the Taranaki District Health Board (TDHB) with advice and input from the Local Advisory Group for Health of Older People Strategy. The members of that Advisory Group represented and communicated with a very broad spectrum of Taranaki providers and consumers. There was also on-going consultation with Maori providers, hospital providers and the Needs Assessment and Service Coordination (NASC) Agency.

To obtain the views of the wider community and the sector interests, a stock take was taken of the district services and the sector were invited to provide their views on the priorities for the next seven years for the health of older people in Taranaki. Ten issues were identified and the three most prominent were prioritised and are attached as Appendix "A".

3.2 Philosophies that Underpin the Continuum of Care ¹

- A focus on keeping well through health promotion and illness prevention strategies and rehabilitation
- Older people being kept well informed
- Older people maintaining a healthy lifestyle
- Older person being involved in decision making and having a choice about services near where they live, i.e. aging in a place where appropriate
- Equitable, easily accessed and culturally appropriate services
- Primary health care playing a key role in care
- Collaboration between health sector professionals and with other sectors
- Culturally appropriate services

3.3 Government Strategies

The Government has produced the Positive Ageing Strategy. This is a strategy that crosses government agencies. The Health of Older People Strategy identifies the need for 'an integrated continuum of care' model, which provides seamless service provision for the older person on their journey through the health care system. These are the guiding documents for the health sector over the next ten years with regard to older people's health services. Other strategies and policies informing the work of the TDHB in this area include the New Zealand Health Strategy, the Disability Strategy, Primary Health Care Strategy, the Maori Health Strategy, the Palliative Care Strategy and the Pacific Health and Disability Action Plan.

3.4 The Taranaki Population

Taranaki, like the rest of New Zealand, has an increasingly ageing population with the large group of 'baby boomers' starting to reach 65 within the next ten years. At present most of the population aged 65 and over are fit and healthy. A minority are frail and vulnerable and require high levels of care and disability support. For some this is due to age related conditions for others it is as a result of chronic illness or disability that may have been present for many years.

This group are generally over 75 years of age, however, for Maori and Pacific People 'conditions of age' are more likely to occur from 55 years of age onwards. Taranaki has a greater proportion of older people now than the New Zealand average (13.8 percent versus 11.8 percent respectively). This group is dominated by non-Maori. People over 65 make up 15.7 percent of the non-Maori population (compared with 13.3 percent in New Zealand overall). Maori over 65 years make up 3.8 percent of the Maori population (the national proportion is 3.5 percent), which reflects higher premature mortality rates among Maori. By 2021 23 percent of the Taranaki population will be 65 and over. By 2021 there will be higher percentages of Maori over 65 year olds.

¹ Ministry of Health

The TDHB, the community, the Advisory Group and pro-active District Councils collectively are the key to the future of Health of Older People Strategy. This requires commitment across the health sector and involves building on the existing excellent relationships and networks.

TDHB's strategic directions as applied to this Plan:

- Focus on wellness through health promotion and maintenance, and illness prevention
- Older people are well-informed and maintain a healthy lifestyle
- Older people have choice about where they live, i.e. ageing in place where appropriate
- Older people are involved in decision making
- Equitable, easily accessed services are available
- Culturally appropriate services
- Primary health care plays key role in care, including health promotion/prevention/early intervention
- Focus on rehabilitation
- Collaboration between health sector professionals

3.4.1 Taranaki Population Statistics

Year	Total Population	65+	Elderly Percentage Growth to national levels
2001	102,786.00	14,517	14.12%
2006	101,230.11	15,208	15.02%
2011	98,799.03	15,930	16.12%
2016	95,978.98	17,299	18.02%
2021	92,769.96	18,483	19.92%
Stratford District Council			
Year	Total Population	65+	Elderly Percentage Growth to national levels
2001	8,883.00	1,260	14.18%
2006	8,700.00	1,243	14.28%
2011	8,300.00	1,194	14.38%
2016	7,800.00	1,130	14.48%
2021	7,300.00	1,065	14.58%
New Plymouth District Council			
Year	Total Population	65+	Elderly Percentage Growth to national levels
2001	66,603.00	9,906	14.87%
2006	68,000.00	10,726	15.77%
2011	67,100.00	11,322	16.87%
2016	65,900.00	12,372	18.77%
2021	64,400.00	13,314	20.67%
South Taranaki District Council			
Year	Total Population	65+	Elderly Percentage Growth to national levels
2001	27,537.00	3,429	12.45%
2006	27,500.00	3,507	12.75%
2011	26,400.00	3,472	13.15%
2016	25,100.00	3,427	13.65%
2021	23,800.00	3,368	14.15%

Taranaki District Health Board population forecast is based on the medium projected population figures from 2006-2021 for the Taranaki Regional Council. Elderly percentage growth assumes National Medium Fertility, Medium Mortality and Long-term Annual Net Migration of 5,000 and was derived from the same source- Statistics New Zealand.

4.0 Discussion on the ageWELL Network Model

The model (see TOPAT Flowchart, page 12) ensures effective and equitable use of scarce resources in a Taranaki wide approach to the organization of health services for older people. It closely resembles the Strategy and Network developed by Waikato District Health Board. (The two districts have similar demographics - two main centres with several smaller rural towns).

This is a long-term strategy to 2010. In the short term it focuses on establishing key Taranaki wide relationships, reviewing referral processes and addressing gaps as identified by the community and the Advisory Committee. In the long term the network would look to achieving health improvements and innovative care through the community and primary health sector.

There is an emphasis on integrated community assessment and rehabilitation services with the proposed establishment of Taranaki Older People Assessment Teams (TOPAT). This will clarify how the specialist health services for older people will interface with personal health, specialist mental health treatment and support, and disability support services for older people.

Key principles of the network will be:

- Sufficient capacity to manage an ageing population
- Client focused seamless services
- Continuity of care
- Single point of entry for non acute referrals
- Connected services
- Specialist and dedicated staff
- Local community action
- A responsive flexible model
- Culturally appropriate
- Building on what is already in place
- Integration
- Prevention and health promotion focus

The network approach, as being established in Waikato¹, appears to be an effective way of bringing together and coordinating the various community groups, activities and support for older people. There are the emerging networks facilitated by the District Council, WITT, Age Concern, Tui Ora Ltd and TDHB. These can be further fostered.

¹ Based on Waikato District Health Board AGEWISE Discussion Document April 2002

Older people mostly keep reasonably healthy and independent lifestyles and many benefit from regular support from family/whanau and community organisations on a regular basis. The first contact with the health system is often with a general practitioner. Community and primary care services are the key to developing a wellness approach to old age and this is where there is an opportunity to achieve health gain and lifestyle improvements. At times older people require episodic care from their general practitioner, as well as elective or acute hospital services which may be followed by inpatient, intermediate care and/or community rehabilitation to assist them to return to independent living at home. They may need intensive treatment services, rest home care or palliative care services towards the end of their lives. The network model needs centralised and specialised Older Person's Assessment Team (TOPAT). TOPAT would link with existing workers in the community and as a result also provide support for Taranaki rural communities.

As a single point of entry for assessment and service coordination these multidisciplinary teams should simplify referral processes and improve access to appropriate and timely care. An 0800 Call Centre system could provide initial assessment and direct referrals to the most appropriate team/service. Another refinement, perhaps further down the track, could be for Elder Care Coordinators to be attached to the Primary Health Organisations (PHOs). They would undertake the proactive assessment and referral function for the PHO. They would also receive notification from the hospital services around time of discharge and be contacted as well for older people seen and discharged from the Hospital Emergency Department.

Other key components in the ageWELL Plan for older people include:

- A Taranaki wide approach to education/training and the promotion of working with older people as a "specialist" and interesting area of work.
- Linking with other District Health Boards for training and development, mentoring and review.
- Transition planning models to improve continuity of care.
- The development of strong inter-sectoral relationships with Work & Income, Housing NZ, District and Regional Councils, ACC, Safer Community Council, Tui Ora Ltd, Ngati Ruanui, other Iwi with Iwi health interests, Te Puni Kokiri. Police and Sport Taranaki to work collaboratively to address community issues.
- The need to address early intervention in relation to Maori and the targeting of health promotion at an earlier age.
- The need to address early intervention in relation to older Pacific Islanders and the targeting of health promotion at an earlier age.
- Fostering current developments in kuia/kaumatua services and the development of culturally appropriate support services, information services and initiatives
- Community accountability through the establishment of a Service for Taranaki Older People Health Strategy Advisory Group.
- A willingness to look at addressing the needs of different communities (rural in particular).
- A commitment to pursue initiatives that would foster ageing in place and support family/whanau and communities to achieve this.
- An investment and commitment to health promotion and prevention approaches based in the community:

- Move it or lose it Classes, Green Prescriptions, Falls Prevention programmes and informal carer support and training programmes.
- Support for opportunistic and planned screening initiatives undertaken by Primary Health Organizations.
- Pharmaceutical reviews of medications.

5.0 ageWELL Key Network Components

5.1 Taranaki Older People Assessment Teams (TOPATs)

These would be established in Hawera and New Plymouth. (91.6 percent of the total population over 65 years in Taranaki lives in these two areas.¹ By 2021 95 percent of the over 65 population is predicted to live in these two areas).

Specialist assessment, treatment and rehabilitation would be centralised in New Plymouth with increased regional access and communication throughout the region via outreach workers. TOPATs would be the link between primary and secondary care and the entry point to health and disability support and services for older people in Taranaki.

Presently there are four main points of entry:

- o NASC agency
- o AT&R (Assessment, Treatment and Rehabilitation) Services
- o Community Health and Disability Services
- o Psychogeriatric Services

The TOPAT would become a single point of referral and assessment, treatment, information and service coordination. It is anticipated the formation of the TOPAT will be worked through with the current providers within the current capacity. The network and TOPAT will facilitate efforts to bridge current gaps and issues in services and access to services.

5.2 Key Functions

Key functions of the team could include:

- o assessments for support, rehabilitation, care packages, and treatment
- o service coordination
- o case management
- o community networking education

¹ Taranaki District Health Board population forecast is based on the medium projected population figures from 2006-2021 for the Taranaki Regional Council. Elderly percentage growth assumes National Medium Fertility, Medium Mortality and Long-term Annual Net Migration of 5,000 and was derived from the same source— Statistics New Zealand.

- information

TOPAT would be responsible for outreach clinics and consult liaison services in rural areas in conjunction with the local coordinators or outreach workers. The opportunity also exists to consider joint clinics with GPs, Maori health providers, or nurse practitioners and field officers for disability organizations in rural areas.

The TOPAT would be multidisciplinary and could be based on existing staff and agencies that currently perform these functions. The composition of teams would change over time based on local need, client need and staff recruitment. The team may include:

Occupational Therapists	Physiotherapists
Service coordinators	Support Needs Assessors
Geriatricians	Psycho geriatricians
Doctors	Mental health professionals
Nurses	Primary health workers
Maori health professionals	Rehabilitation specialists
Pharmacists	Social workers

The core TOPAT needs to be supported and advised by other key specialist groups and members of the ageWELL Health Network. This should include representatives from Primary Health Organisations, General Practitioners, Pharmacy Liaison, Maori Health, ACC representatives, cultural advisers, consumer and disability advocacy and advisory groups.

5.3 Taranaki DHB Older Persons' Service TOPAT Flowchart

5.4 Benefits of the network and TOPAT to consumers

Benefits of the network for consumers should include;

- Key identifiable contacts for elder peoples services within primary and secondary health and community settings
- Quicker and easier access to services and information and the ability to access a team of people and skills
- Consistent support which takes account of a wider range of health and social care needs
- Kuia and kaumatua services enhanced
- Early identification and intervention services leading to more appropriate and timely treatment services
- Hospital stays seen by older people as a positive intervention in a long term plan to support people in their own homes
- Providers coordinating their services around the needs of older people in a way that appears seamless to those receiving the services
- The ability to support older people and their carers in their own environments for longer.

5.5 Network Projects

The ageWELL network will be able to have input into the recommendations for the delivery of special projects, joint ventures or pilots via the Health of Older People Strategy Advisory Group. The Advisory Group will recommend two or three priority projects each year for consideration by the TDHB Board, and these would be carried out in collaboration with the primary health sector and community support organizations.

Service needs and gaps identified by the Health of Older People Strategy Advisory Group have formed the basis of the suggested projects. These have been prioritised for the years 2004-2006 for consideration of the TDHB Board. Further examples of projects that could be developed by TDHB and members of the network are also attached. Please see Appendix B.¹

6.0 Changes to the current system proposed by the ageWELL and Network Model ²

The model recommends changes to existing processes for referral and assessment. While there is currently no formal network or key contact point for older people, the most significant change would be to move to a single point of entry and subsequent practice

¹ Based on Waikato District Health Board AGEWISE Discussion Document April 2002

² Based on Waikato District Health Board AGEWISE Discussion Document April 2002

⁴ Based on Waikato DHB AGEWISE Discussion Document April 2002

assessment process for referrals. This would result in improved access to appropriate assessments and accessing support needs in conjunction with treatable medical problems. (These treatable medical problems are often the cause of the support needs.)

6.1 Alignment with National Policy Frameworks

The network concept is consistent with broad level national vision and principles incorporated in the Positive Ageing Strategy and Health of Older People Strategy. In particular, the network supports the identified need for a significant change in the way health and support services are provided to older people. These include; greater co-ordination and integration of services, improved and timely access to services and information, trends toward prevention and early intervention as well as community initiatives and workforce development.

It is the projects that develop from the network that are likely to align more specifically with the Health of Older People Strategy action points. These include public health initiatives and programmes, culturally appropriate care models, flexible support options, ageing in place and community based care.

6.2 Implementation of the Model

The ageWELL vision requires a minimum 3-year establishment phase.

It is recommended that resource be made available to scope, assist implementation of, monitor and evaluate the various projects that are approved to assist the implementation and effectiveness of the model. See Appendix B for projects, which have been suggested by various groups.

In addition links will be further developed with current community/consumer based groups that are able to advise about the implementation of ageWELL. The ongoing involvement of consumers in the network will ensure that any services developed meet their specific needs.

One of the key principles of the establishment phase is to undertake and complete the establishment in sections rather than trying to set the whole up from the outset. This would allow for the network concept to mature and ensure that each component completed.

7.0 Conclusion

This is an exciting time for older people's health services. An integrated continuum of care, underpinned by the District Health Board holding both personal health and disability funding, provides opportunities for the DHB to be innovative in how it provides services to our 65 and over population. The proposals will require individuals and groups to continue to work together to create services which will effectively ensure that older people receive "the right service in the right place, at the right time and from the right provider."

Appendix A

Taranaki Identified Emergent Issues

COORDINATED SERVICE APPROACH

Services across the sector are currently fragmented and there are a number of points of both entry and exit from a number of services.

For older people, gaps in care can mean the difference between regaining an independent life at home, or not.

Lack of integrated services can create expensive duplication of effort and cost implications.

Effective preventative, early intervention and rehabilitation services have an essential part to play in helping older people maintain their independence and good quality of life. Effective community rehabilitation services can prevent the need for older people to be admitted to hospital, facilitate their discharge from hospital and reduce their reliance on institutional care or community services.

Key strategies in the short term would focus on building key Taranaki wide relationships, reviewing referral processes, building on identified strengths and addressing the gaps and duplications within the primary/secondary health service interface. The strategies would include developing a network model with a focus on promoting healthy lifestyles, illness prevention, early intervention and community rehabilitation.

EDUCATION AND INFORMATION SHARING

The older person's various health providers need speedy access to the same kind of health and support needs information. Information needs to be shared and made available in a timely fashion so that as older people move from one sector to another their needs, wishes and health information is immediately available to the treating health team members.

As well, older people, families and whanau often don't know how to obtain information on groups and services. They need easily accessed contact information that is up to date and relevant.

Key strategies would involve developing information systems that would allow the older person to carry a summary of their base health and drug information with them. This would include when they were seen last, by whom and include medication and treatment changes. The booklet could also contain health promotion information and contact phone numbers for disability groups and support and information groups, informal family carer networks etc.

Access to information via 0800 telephone numbers for rural older people would be considered.

WORKFORCE

It was identified that there were significant workforce recruitment and retention issues across the Older Person Service sector. This was within both the provider arm in areas such as AT&R, therapy teams and within the residential providers particularly related to caregivers.

There is a need for a Taranaki wide approach to education/training and the promotion of working with older people as a “specialist”, interesting and attractive area of work.

A key strategy would be to develop a workforce development plan which would focus on marketing Taranaki as an attractive place to work, training and upskilling packages which could include scholarships for key staff to undertake further study and research, development of geriatrics/ gerontology as progressive specialty areas to work in.

Appendix B⁴

Suggested Projects from the Plan

It is intended to determine appropriate projects to enhance the implementation of ageWELL with the stakeholder advisory group. Then a brief scope of the planned project(s) will be submitted to the TDHB for approval.

INFRASTRUCTURE PROJECTS

- AT&R project re TOPAT establishment/Community rehabilitation/crisis response
- Cost/benefit analysis of discharging patients with 7 days medication
- Assist in the establishment of ageWELL network
- Home based support and care projects
- Improve the inter-sectoral coordination between service providers
- Investigation of a central information service eg. 0800 number
- Investigation of feasibility of "patient held plans"¹
- Scoping the links of TOPAT information through PHO framework
- Cost/benefit analysis of prevention, screening and wellness checks for older people

WORKFORCE PROJECTS

- Scope implementation of appropriate best practice model for key worker/case management of high and complex needs clients
- Workforce development projects to attract and retain specialist staff in Taranaki

SERVICE DEVELOPMENT PROJECTS

- Support access to options that address social isolation issues for older people
- Best practise review of medication/polypharmacy
- Coordinating existing health promotion initiatives
- Develop an action plan to implement the MOH Health of Older People Strategy
- Develop education programmes to promote healthy ageing strategy
- Evaluate discharge planning processes
- Establish ageWELL Advisory Group
- Implementation of a best practice model for people with high and complex needs
- Support various health promotion projects¹

¹ A Patient Centred Model for Integrating Primary and Secondary Services for Older People, Koura and Kuia with Multiple and Complex Conditions. (Final report 29/08/02)

- Progression of culturally appropriate assessment and service models
- Support falls prevention projects

Projects identified and for further consideration and prioritisation. Those that may be recommended for implementation for 2004 - 2006 include the following:

INFRASTRUCTURE PROJECTS

- Assist in the further development of the ageWELL network
- Work with current provider(s) of information service(s) to determine application as an effective central resource for older people
- Investigation of feasibility of "patient held plans"², recommended as project in 2006, rather than immediately, to link in with any further IT development for the TDHB
- Support falls prevention projects

WORKFORCE PROJECTS

- Scope implementation of appropriate best practice model for key worker/case management of high and complex needs clients
- Workforce development projects to attract and retain specialist staff in Taranaki

SERVICE DEVELOPMENT PROJECTS

- Determine all health promotion projects being delivered to older people sector and work with providers to further facilitate and support same
- Improve the inter-sectoral coordination between service providers
- Develop service specifications for all service provider agreements to ensure older person friendly services.

¹ Focusing on Taranaki DHB – District Strategic Plan 2002 – 2012 health prioritisation

² A Patient Centred Model for Integrating Primary and Secondary Services for Older People, Koura and Kuia with Multiple and Complex Conditions. (Final report 29/08/02)