Moving to an Enhanced Model of Home Based Support

Lisa Gestro
Planning and Funding Manager
Auckland District Health Board

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Outline

- *The Problem*
- *The Vision*
- *The Methodology*
- *The Model*
- *The Outcomes*
- *The Points of Difference*
- *The funding*
- *The lessons*
- *The next steps*

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The Problem?

- *A completely unsustainable service model that was costing an additional 18% year on year for no additional obvious gain*
- *Complete lack of transparency in terms of outcome*
- *Massive duplication of assessment and intervention*
- *An inflexible system that provided no ability for providers to work innovatively, or for older people to have a say in their care*

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The Vision?

'To provide support services for older people which are seamless, inclusive and well coordinated'

By

- streamlined access to services through a single point of entry

- Provision of home care which is not about home care, but about meeting identified goals for independence through any reasonable means

- Development of a robust funding methodology which removed barriers to innovative practice

-Implementation of a single assessment

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The methodology

- *Created a vision and went to the market to recruit partners to work with us on the development and implementation of the vision*
- *A rigorous selection process resulted in 4 provider partners*
- *Development of the SDG crucial to success – not unlike alliance contracting*
- *Phase one of the model went live in July 2009*
- *2009/10 transition year*
- *Model now in place but there are still lots of things that we could be doing better*

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The Role of SDG

- *Governance group comprising each of the 4 providers, specialist services and DHB*
- *DHB chairs the meeting but each member has equal say in decisions*
- *SDG reviews performance, raises issues and makes policy decisions*
- *Members act for the greater good rather than for the good of their individual agency*
- *Changes to the model are all agreed by SDG*

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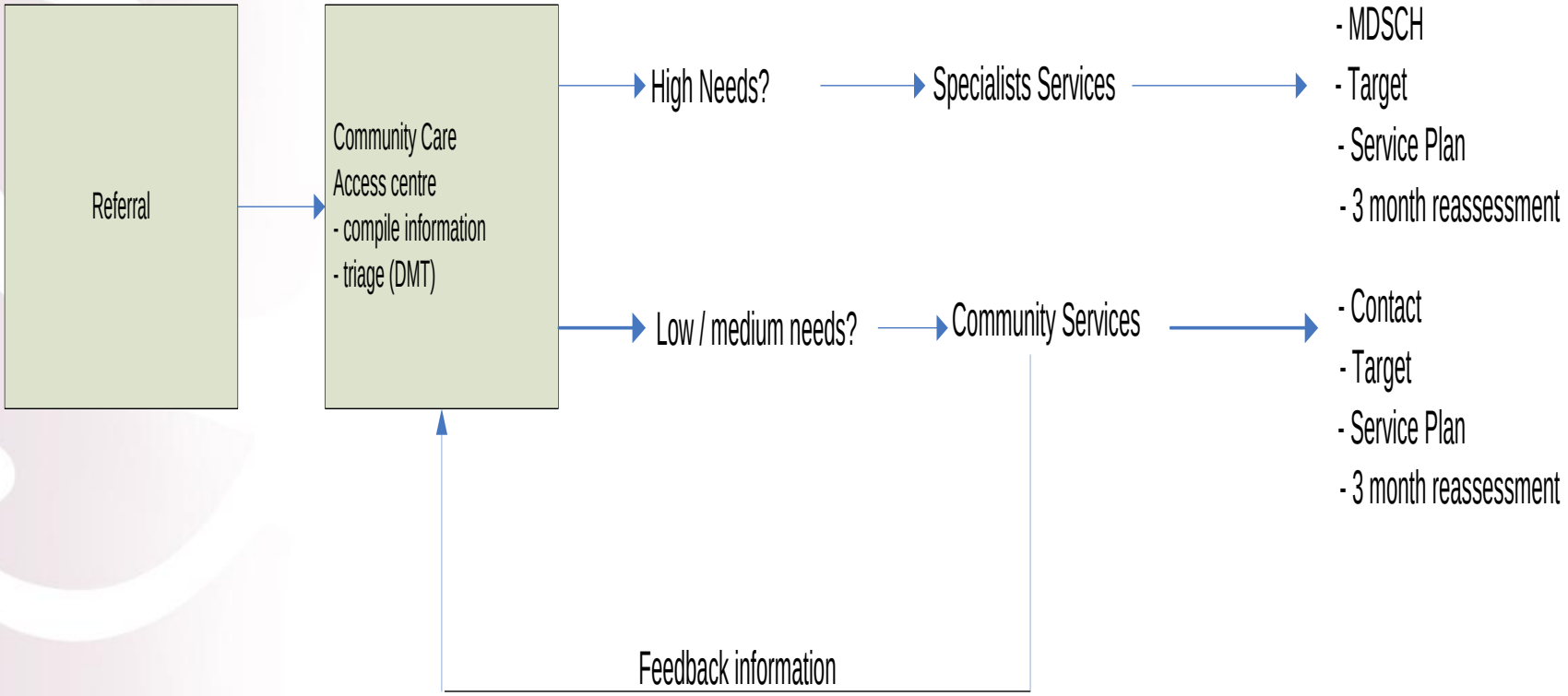
So what is the model?...



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Key features of the Model

- *Providers have responsibility for assessment, care planning, resource allocation, care coordination and reassessment*
- *Clinical care coordinatiors in the community*
- *Every client gets an initial face to face assessment*
- *They have direct access to specialist services for support and advice*
- *Packages are provided for clients who wouldn't qualify for care under other models*
- *Providers have complete responsibility for meeting the identified goal and for coordination of all aspects of care – funded and unfunded*

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An example

Mr A

- *Diagnoses: Mental health issues (Schizophrenia), Obesity, HTN, CVA, Diabetes Type 2*
- *Social Dynamics: Few family supports, isolated, lives in Housing NZ small unit*

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JUST
JUICE

Plan for Mr A

- *Initial Goal: To build up relationship with Mr A during the next 6 weeks to gain his trust so that we can work with him*
- *Service Plan: - plan to review in 6 wks*
- *2 staff: 4hrs / wk x 2 wks then 1 staff: 2hrs per wk x 4 wks*
- *Home Help + take laundry to laundrette until client has Washing machine*
- *Socialisation: Talk re weekly events, news items, topics of interest*
- *Positive Outcomes:*
- *Client is building rapport with male carer*
- *Client is doing some of the house cleaning with encouragement of carer – and is taking pride in it*
- *Future Goals:*
- *F/U washing machine*
- *Address clients personal hygiene issues - we need to build up trust/confidence of client*
- *Look perhaps at socialisation options, family involvement, integration into the community.*
- *Client to be independent with Home Help*

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Case Mix

- *Case Mix is a national project that ADHB is leading with the University of Auckland and SDG*
- *CCHDHB, CDHB and NMDHB partners in the project*
- *Case Mix is the funding of services according to its individual cost component - product specification*
- *Case Mix previously the domain of acute services – informs DRG's*
- *Case Mix just one part of the equation*

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Lessons learnt

- *Don't make large scale change in the absence of systems to support them*
- *Data – is key to informing decisions. The model can be hazy but the data to support it definitely shouldn't be*
- *Support – don't underestimate the number of man (and more importantly woman) hours required to make this happen.*

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Next Steps

- *Expand the philosophy into residential care - align the two models - roundabouts not traffic lights!*
- *Convince specialist services that HBSS can do more*
- *Align the model to the Better, Sooner, More Convenient activity*

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Key messages

- *Take the time to ensure that others share the vision, you can't 'impose' this kind of change on people*
- *Everyone from support workers up must own and believe in the model to sell the story*
- *If your model is based on need and not entitlement the rest falls into place*
- *Older people are what we are here for, never get too far away from the grass roots to forget that*
- *And finally, have a forgiving group of providers!*

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