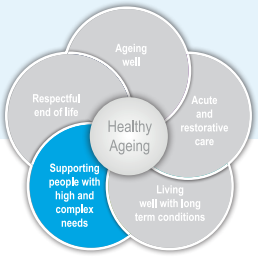

SUPPORTING PEOPLE WITH HIGH AND COMPLEX NEEDS

He tautoko i te hunga pakeke he uaua, he maha hoki o rātau taumahatanga

GOALS

- Older people with high and complex needs:
  - » are able to live as independently and actively as possible
  - » have the information and freedom to make good choices about the care and support they receive
  - » know that health care workers understand their wishes and support their needs
  - » are assured that information about their circumstances and needs flows easily between health care workers in an integrated manner
  - » have care plans that reduce the likelihood they will deteriorate markedly after a health event
  - » are able to access care and support irrespective of their financial position
  - » experience equitable access to services and equitable outcomes no matter their ethnicity or location
  - » move easily to and through care settings that best meet their needs
  - » have reduced need for acute care.
- Families, whānau and carers have the support, information and training they need to help the older people they care for and the stress of caring does not affect their own health.
- District Health Boards (DHBs) bring together data from various sources, know the value and quality of the care they provide for older people in their district and can easily learn from other DHBs.

15. Focused care of frailty in the community.

15a Develop frailty pathways and identify and treat frailty in the community.

Implementing this action during 2019-2022 involves:

- implementing nationally consistent frailty identification tools in a cross-system approach to enable early identification of risk and improve links to all necessary supports, treatment and rehabilitation services
- DHBs engaging with primary care on available frailty identification tools, with expectations of sharing frailty risk data across the system
- the Ministry of Health sharing information on preferred nationally consistent frailty identification tools along with the algorithm to analyse the case management system and process within primary care, with the aim of using the information effectively in New Zealand.

LEAD: Primary Health Organisations (PHOs), DHBs

KEY PARTNER: Ministry of Health

MINISTRY OF HEALTH
MANATŪ HAUORA

19. Better integrate services for people living in aged residential care.

19a Better integrate primary care and aged care services.

Implementing this action during 2019-2022 involves:

- alignment with other programmes for collective impact – in particular, Actions 15a and 20c; and 6b (falls and fracture prevention and management)
- the National Ambulance Sector Office (NASO), aged residential care representatives, DHBs and St John New Zealand discussing how to improve processes for non-emergency transfers involving aged care residents
- DHBs and NASO developing options for funding non-emergency transfers for aged care residents
- implementing the recommendations from the PHO Service Agreement Amendment Group (PSAAP) to identify areas within the PHO Services Agreement and the Aged Related Residential Care Agreement that should be aligned to support better access to general practice care
- DHB Shared Services, through and on behalf of the DHB Health of Older People Steering Group, developing a service integration plan with representatives from DHBs, aged residential care, pharmacy, primary health care and the ambulance service sector. The plan will deliver a standardised approach to referral and discharge protocols for aged care residents across these providers
- reporting progress to the DHB Health of Older People Steering Group and PSAAP.

LEAD: DHBs (via DHB Shared Services)

KEY PARTNERS: Consumer representatives, New Zealand Aged Care Association and aged residential care providers, pharmacists, PHOs, ambulance providers, Ministry of Health

17. Integrate funding and service delivery around the needs and aspirations of older people to improve the health outcomes for priority population groups.

17c Develop systems to improve identification of socially isolated, vulnerable older people.

Stakeholders thought this action should start and be clustered with Action 3a.

Implementing this action during 2019-2022 involves:

- reviewing findings from 'social prescribing' pilots and 'navigator/haumoana' approaches that optimise access to primary care
- aligning with the *Better Later Life* He Oranga Kaumātua 2019-2034 strategy initiatives and *New Zealand Carers' Strategy* Action Plan for 2019-2023 actions.

LEAD: DHBs

KEY PARTNER: Government agencies, non-governmental organisations (NGOs), Primary Health Organisations (PHOs)

20. Improve integration of information from assessment and care planning with acute care services and with those responsible for advance care planning.

20c Care for people on the basis of shared care plans in multi-disciplinary teams.

Stakeholders thought this action should start and be clustered with Action 9c.

22. Build the resilience and capability of family and whānau, volunteer groups and other community groups that support older people with high and complex needs and end-of-life care needs.

22a Improve support for informal carers, including respite care; guidance and information; and training.

Align with the *New Zealand Carers' Strategy Action Plan for 2019–2023*.

Implementing this action during 2019-2022 involves:

- linking to paid carer legislation
- linking with disability support services, home and community support services, day services and respite care.

LEAD: Ministry of Social Development

KEY PARTNERS: Ministry of Health, Ministry of Business, Innovation & Employment, Accident Compensation Corporation (ACC)