

Ageing in MidCentral

Health of Older People Strategy



September 2004



MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tairāia

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INTRODUCTION

MidCentral District Health Board is responsible for planning and purchasing most health services for the 160 000 people¹ living in the following territorial local authority districts:

- Manawatu district
- Palmerston North city
- Tararua district
- Horowhenua district
- Otaki ward of Kapiti Coast district.

MidCentral District Health Board was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000. It has three key functions:

- Governing and managing the District Health Board
- Planning and purchasing health and disability services
- Delivering health and disability care services through Crown owned hospital and associated services.

District Health Boards are also charged with working across the wider district and communities in a more inter sectoral approach than was traditionally taken by health planners and funders.

Priorities and Plans

MidCentral District Health Board's activities are guided by four key health and disability strategies established by the Government. These are *The New Zealand Health Strategy* (December 2000), *The New Zealand Disability Strategy* (April 2001), *The Primary Health Care Strategy* (February 2001) and *He Korowai Oranga - Maori Health Strategy* (November 2002).

The Government also has 10 priority areas for District Health Boards:

- 1 Reducing the incidence and impact of diabetes

¹ See appendix two for demographics

- 2 Implementing *He Korowai Oranga - Maori Health Strategy* and *Whakataataka – Maori Health Action Plan 2002-2005*
- 3 Reducing inequalities
- 4 Implementing the mental health blueprint
- 5 Progressing the implementation of the *New Zealand Disability Strategy*
- 6 Developing Primary Health Organisations
- 7 Addressing waiting times for specialist elective services
- 8 Keeping infrastructure costs as low as possible and on budget
- 9 Developing and maintaining good industrial relations
- 10 Producing, developing, and implementing innovative approaches so those health services are delivered within the funding available.

In 2001 the MidCentral District Health Board's *District Strategic Plan* was developed. It provides a 5 to 10 year outlook for the District Health Board. It outlines the vision that the “*people of our district enjoy the best possible health and independence.*” See Appendix One for the outcomes that will result when the vision is achieved.

Beneath the *District Strategic Plan* are four strategic areas:

- the *Primary Health Care Strategy*, to provide overall direction for the development of primary health care services in the district
- the strategy for secondary² and tertiary services³
- the *Ageing in MidCentral - Health of Older People Strategy*
- the *Referred Services Management Strategy*⁴.

Why an Ageing in MidCentral Strategy?

District Health Boards must implement the Government's *Health of Older People Strategy* by 2010. In order to achieve this, MidCentral District Health Board consulted with older people within the MidCentral District, their family and whanau, the wider community and service providers.

² ie hospital and specialist services

³ ie very specialised services usually provided at national centres

⁴ ie community referred pharmacy, laboratory and radiology services

As a result of consultation, the AIM Strategy includes an integrated continuum of care model, which is a framework for the implementation of the Government's *Health of Older People Strategy*.

The aims of the Government's *Health of Older People Strategy* which underpin the AIM Strategy are:

- improve and support independence and choices
- improve older people's ability to live at home, or in their place of choice, longer
- support older people, their carers/whanau and networks to live in their Community ensuring their lives are healthier and meaningful to them.
- be proactive and reduce the number of admissions to hospital, especially where this can be prevented with, for example, better information and earlier care.

Current Services

On 1 October 2003 funding and contracts relating to the provision of disability support services for older people (those aged 65 years and over) were devolved to District Health Boards from the Ministry of Health.

MidCentral District Health Board took over responsibility for planning and funding the following services:

- Aged residential care, including rest homes, continuing care (hospital-level beds), dementia, and psychogeriatric services
- Carer support and respite for older people
- Assessment, treatment and rehabilitation services
- Home-based support services for older people, including personal care, household management and night relief
- Needs assessment and service co-ordination for older people.

MidCentral receives approximately \$32 million dollars to fund age-related disability support services, of which approximately \$20 million (62.5%) is currently used to purchase aged residential care services.

MIDCENTRAL'S STRATEGY FOR THE HEALTH OF OLDER PEOPLE

Vision

MidCentral shares the same vision for the health care of our older people with that of the Government's *Health of Older People Strategy*:

“Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whanau and community life. They are supported in this by coordinated and responsive health and disability support programmes.”

Source: Health of Older People Strategy, April 2002

By 2010 MidCentral wishes to see this vision achieved – and thus an integrated continuum of care - with the help of health and disability support service providers, Maori, and the community. This means older people will have access to coordinated and suitable services from a range of providers in a way that meets their diverse individual needs.

Values

The values we will hold in achieving the vision, are:

Appropriateness

Embracing cultural diversity, being culturally aware and working with Maori to meet the needs of the Maori community

Care and respect

Developing a culture that values and respects older people, their rights and their opinions across the whole community

Community involvement	Providing resources to ensure older people, service practitioners and the community are adequately informed, educated and advised about health and disability services
Customer focus	Having a person centred approach to service delivery where individual choice and need is the focus
Partnership and continuity	Having a collaborative, inclusive and responsive approach that promotes integration and coordination of services
Professionalism	Providing a quality service based on best practice that is outcome focused and delivers a rights based service that demonstrates valuing of older people.

Objectives

We have identified eight objectives aimed at improving health outcomes and independence for older people, and achieving integrated continuum of care. These objectives support the achievement of the eight goals set out in the *Health of Older People Strategy* which have been adopted for *Ageing in MidCentral*.

Access	Older people throughout the district will have ease of access to older-person focused healthcare services.
Analysis of population needs	An assessment, focussing on older people's health and including avoidable admissions, demographic status, and the level of involvement of older people in Primary Health Organisations, identifies the population needs.
Co-ordination	Services will be co-ordinated and responsive to the needs of older people. A key person will be available to help older people to coordinate their services.

Eligibility	<p>There is increased flexibility within service provision and health inequalities are addressed through the review of eligibility criteria.</p>
Information and participation	<p>Appropriate information is shared between providers - promoting better coordination of services and a smoother transition between services – to reduce the stress on older people.</p> <p>Older people will be well informed and able to easily access information, advice and support.</p> <p>Older people, family and whanau will be included in decision making.</p>
Maori specific services	<p>In partnership with Maori cultural based service options will be developed that reduce disparities but retain and develop rangatiratanga.</p> <p>Leadership and guidance will be taken from <i>He Korowai Oranga</i>.</p>
Wellness	<p>Older people will be supported to live as independently as possible. There will be a focus on prevention of illness and injury. When required there will be access to rehabilitation services within the community to assist people to stay in their own home as long as possible.</p> <p>MidCentral District Health Board will support the provision of appropriate services that reduce social isolation.</p>

Workforce development

There will be planned infrastructure development to ensure the training needs of carers are met. This will improve the quality of provision of care and reduce risks of elder abuse.

Integrated Continuum of Care: Aiming for the Future

The integrated continuum of care model which underpins *Ageing in MidCentral* sees collocation of health and other support services as the optimum.

Collocation means the services are either together in one place, for example local primary health care services, or are accessed through one place within the community. This goal of collocation is to make it easier for older people.

The main service areas that could be collocated are:

- Information and advice – people trained and specialising in supporting older people about what services are available, how and where to access them and assistance with filling in forms. Groups with important information include various Government agencies such as the Territorial Local Authorities, Housing New Zealand, Work and Income and the proposed AIM information service
- Assessment – needs assessment and service coordination including having key workers for those older people who need it
- Primary health care – primary care professionals (GPs, practice nurses and other primary health care professionals)
- Laboratory testing – eg getting your blood taken for tests
- Pharmacy – so medications are easy to get
- Specialist aged care practitioners, eg those from the STAR unit at Palmerston North Hospital
- Field workers and/or social workers to have time to support people, assist with access to services, benefits, information and health education
- Allied support services such as physiotherapists, occupational therapists, speech language therapist, nutritionists, dietitians and some complementary medicines

- District nurses and home support services
- Community mental health.

Collocation does not mean all staff and/or volunteers need to work for the same organisation.

Consideration must be given to fostering and developing services that are responsive to the cultural norms of Maori.

The continuum of care strives to provide older people with ease of access to a range of services. Such services could be provided in the person's place of residence or be collocated. The aim is to have seamless access to services; the need to move from one location to another is to be minimised.

Pictorially, the continuum of care would look like this.



THE STRATEGY'S KEY ACTIONS

The following eight aims are the goals of the *Health of Older People Strategy* which have been adopted for *Ageing in MidCentral*. 74 key actions have been developed that, when implemented, will achieve the vision and objectives of both these Strategies.

AIM 1 - Choices and information

Older people, their families and whanau are able to make well-informed choices about options for healthy living, health care and/or disability support needs

Priority	Action	AIM 1 – Choices and information
High	1	Establish a service model and fund an inter sectoral AIM information and advocacy service available to all older people of the MidCentral district and those who might assist with supporting older people.
Medium	2	Encourage through suitable arrangements more timely and appropriate information sharing between providers and agencies so that information is both current and accurate. This should also reduce the need for older people to repeat themselves unnecessarily. Electronic and national information networks will be utilised where possible.
High	3	Work with providers to require services to involve older people to take the lead role in developing their own plans to meet their health and disability needs. They may be supported with this by advocacy services so that they are able to make informed choices.
High	4	Work with providers to ensure that where it is appropriate there is the opportunity for family involvement in decision making.
Medium	5	Work with providers to further develop a broad multi-disciplinary approach to meeting older people's needs through improved inter sectoral relationships and information sharing.

Priority	Action	AIM 1 – Choices and information
High	6	Enhance inter sectoral relationships through meetings and provider requirements to include information sharing in an effort to prevent, identify and reduce elder abuse.
High	7	Work with providers and other agencies to increase the use of the elder abuse family violence intervention guidelines (Draft, Ministry of Health, December 2003) as a framework for assessing and intervening where abuse is suspected or identified in a timely and culturally effective way.
High	8	Work with providers and the wider community to establish a process to assist identified high-risk older people to meet people and maintain social networks. The AIM Information and Advocacy services will have a role in supporting this to occur.
Medium	9	Establish and facilitate programmes to increase community awareness of elder abuse and educate carers.
High	10	Promote positive attitudes towards older people by requiring providers to be more responsive to older people and ensuring the DHB services model excellent behaviour in this regard.
Medium	11	Invest in workforce development of carers through the development and funding of a workforce development plan that is targeted to services for older people.
Medium	12	Increase home-based rehabilitation options and assistance for older people to stay at home as long as possible including, respite care options.
High	13	Reduce health inequalities and improve health and independence outcomes through culturally appropriate collaboration with older people, their families and communities.

AIM 2 - Policy and service delivery

Policy and service planning will support quality health and disability support programmes integrated around the needs of older people

Priority	Action	AIM 2 – Policy and service delivery
High	14	Establish a sector reference group focused on and including older people to assist in identifying barriers to the implementation of the integrated model of care and advise the DHB on the best way forward.
High	15	Involve local iwi, ACC, Territorial Local Authorities and other agencies in the sector reference group to ensure health promotion and coordination of services and initiatives are inclusive and appropriate for the MidCentral community.
High	16	Implement the integrated model of care (AIM information service, linkages between providers, coordinated care options) and ensure associated performance indicators are developed and monitored so progress can be measured.
Medium	17	Ensure the MidCentral population based needs analysis has a focus on older people to assist in planning and reviewing priorities for services.
Medium	18	Ensure the MidCentral workforce analysis has a focus on older people to determine current and future workforce issues and requirements.
Medium	19	Make sure through contracts and monitoring that the training requirements and competencies of the Health and Disability Sector Standards and when mandatory, the Home and Community Health Standard, will be the minimum acceptable standards for provision of care.

Priority	Action	AIM 2 – Policy and service delivery
Medium	20	Identify continuing aged care educational opportunities for the community and establish an action plan to implement a programme.
Medium	21	Establish a process for training and funding that supports family members and other informal (unpaid) carers involved in providing homecare services.
Medium	22	Develop a Pacific health workforce to help identify and address issues specific to Pacific Peoples.
Medium	23	Invite other community groups to make submissions for the provision of services that will better meet their healthcare needs. These will be considered by the sector reference group and may be incorporated into the strategic plan.
Medium	24	Review bi-annually the priorities in this strategic service implementation plan to ensure continued alignment of priorities to need.
Medium	25	Require Enable New Zealand to undertake a review of delays associated with fitting of equipment and home alterations for older people and work with allied support services to put systems and processes in place to minimise delays for quality and cost effective outcomes.

AIM 3 - Funding and service delivery

Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whanau and carers

Priority	Action	AIM 3 – Funding and service delivery
Medium	26	Review the funding and access criteria process for home support services, dental, vision and hearing services with a view to improving access, flexibility and eligibility. Where these are national criteria work with funders and policy makers to highlight issues and assist with reviews.
High	27	Increase older people’s access to home support services including homecare, district nursing, respite and home help, through distribution of information, review of access criteria and appropriate funding levels.
High	28	Ensure information sharing and needs assessment and service coordination with other services is improved, reducing the need for older people to have to repeat themselves unnecessarily.
High	29	Require involvement of Maori, Pacific People and other ethnic community advocates in the assessment process of older people to ensure an accurate and appropriate assessment occurs.
Medium	30	Complete a review of psychogeriatric continuing care services for the MidCentral District to ensure there are adequate resources available for the provision of services.

Priority	Action	AIM 3 – Funding and service delivery
High	31	Continue to contract Central Region Technical Advisory Service to ensure all dementia and psychogeriatric continuing care services are audited routinely and by exception as required.
Medium	32	Ensure a psychogeriatrician's review occurs in response to a patient referral in a timely manner.
Medium	33	Ensure all providers of services meet all legislative requirements and standards in relation to providing care and support to older people with dementia through monitoring of contracts.
High	34	Complete the specialist services review and use the results to assist with future planning of services. The review will include information sharing and waiting times.
High	35	Establish out-reach clinics for some specialist outpatient clinics currently undertaken at Palmerston North Hospital as collocated services throughout the MidCentral District. These services will have adequate parking and disability access.
Medium	36	Develop and implement an outpatient booking system that ensures timing of appointments is appropriate to older people. For example, appointments are not too early or too late in the day, multiple clinics are aligned where possible, and notification of cancellation will occur in a timely manner to avoid unnecessary travel.
Medium	37	Review reserved parking and disabled parking availability, quantity and location at Palmerston North Hospital for outpatient clinics and older people visiting to improve access for older people.

Priority	Action	AIM 3 – Funding and service delivery
High	38	Review transportation from rural locations to Palmerston North Hospital and establish a system that provides acceptable transportation options for older people who need to attend clinics at the hospital. This will include investigating joint district options such as the ambulance service, ACC and Territorial Local Authorities. Issues related to volunteer driver co-ordination, insurance and legal implications will form part of the review.
High	39	Fund community based Maori liaison key worker position(s) to assist older Maori to access information and services and be a first point of contact if desired. Link this service to a marae based service and / or the AIM information service.
Medium	40	Develop workforce and provider skills to create a more culturally aware and skilled workforce that is cognisant and responsive to Maori culture.
Medium	41	Establish a field worker position(s) as part of the AIM Information and Advocacy service to work with older people at high risk of social isolation. This will include investigating intermediate care options (ie slow stream rehabilitation) and community integration introduction.

AIM 4 - Appropriate Maori integrated services

The health and disability support needs of older Maori and their whanau will be met by appropriate, integrated health care and disability support services

Priority	Action	AIM 4 – Appropriate Maori integrated services
High	42	Continue to work with local iwi and Maori communities in planning, purchasing, delivering and monitoring culturally appropriate services for kaumatua and kuia and their whanau.
High	43	Establish collocated Maori elder care and primary care services in conjunction with Primary Health Organisations - marae-based where possible.
High	44	Investigate the development of home support options to specifically meet the needs of Maori and implement recommendations.
Medium	45	Provide funded training for whanau caring for older people.
High	46	Increase the involvement and ensure Maori service providers or Maori advocates participate in all needs assessments of Maori older people undertaken by the Needs Assessment Support Service.
High	47	Develop and implement a plan that creates respite, convalescent and palliative care options for Maori that are culturally appropriate.

Priority	Action	AIM 4 – Appropriate Maori integrated services
Medium	48	Review current long term living options that are available to kaumatua and kuia. If required put systems, processes and new services in place that are acceptable and culturally appropriate.
High	49	Require He Korowai Oranga - Maori Health Strategy (November 2002) to be used as a framework by all providers to ensure culturally appropriate provision of care.
High	50	Make AIM information services culturally appropriate and include Maori representation and Maori advocates in representation for development and management of the service.

AIM 5 - Promotion and prevention

Population-based health initiatives and programmes will promote health and wellbeing in older age

Priority	Action	AIM 5 – Promotion and prevention
Medium	51	Work in partnership with other agencies and providers such as the local authorities and primary health care organisations to support programmes that reduce social isolation, improve physical activity, prevent falls and improve nutritional status of older people.
Medium	52	Provide additional support to older people at risk of social isolation by improving social connections between older people and the wider community, through development, linking and funding of innovative community based services.
Medium	53	Coordinate facilitation of public meetings for older people through the AIM information service to address issues such as financial planning education for meeting health care needs and a wellness model for retirement.
Medium	54	Work inter sectorally to address areas for public health action such as wellbeing, social isolation, smoking cessation programmes for older people.
Medium	55	Investigate funding options to support older people living at home who have one-off needs that can negatively impact on their health status such as the need for spring cleaning once per year. This may include working with other agencies and the local council to offer assistance with housing issues such as a lack of insulation.

AIM 6 - Timely access

Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning

Priority	Action	AIM 6 – Timely access
High	56	Investigate and establish a system to identify older people at risk who would benefit from additional services and resources.
High	57	Increase support to older people identified as being at risk through funding field worker and advocacy support, assisting in integration back into the community and providing any information and advice they need.
High	58	Work collaboratively with other services such as primary health care organisations on initiatives AIMed at early detection of disease or disability for example vision, dental and hearing examinations.
High	59	Work with the project to implement the Primary Health Care Strategy (2004) as it is complementary to this strategy. Specifically ensure , when developing PHOs, the primary care workforce is trained in health of older people.
Medium	60	Promulgate clinical guidelines and best practice protocols for the management of common age-related health problems in primary health care setting.

Priority	Action	AIM 6 – Timely access
Medium	61	Ensure costs (fees) from providers to older people for health care are in line with legislative (ie Social Security Act) requirements. People will be informed of funding, eligibility criteria and support options available to them through the AIM Information service. Flexibility will be built into current systems where possible.
Medium	62	Review the current provision of services delivered or available rurally, considering access to emergency and after hours medical services. Systems will be put in place to better support rural areas that need this.
High	63	Develop a system to monitor and assess the impact of waiting times for access for older people to targeted District Health Board funded and delivered (hospital and health services) services. Utilise this information in future planning.

AIM 7 - Integration

Admission to general hospital services will be integrated with any community-based care and support that an older person requires

Priority	Action	AIM 7 – Integration
High	64	Assist providers to link information systems where appropriate, with a specific focus on coordination of services so they can ensure an overview of hospital admission and return home, especially where support may be required.
Medium	65	Options to support older people to remain in their own home safely will be explored and implemented.
Medium	66	Ensure a continued focus in funding and planning priorities to avoid unnecessary hospital admissions – working in a wellness model of prevention and maintaining independence.
Medium	67	Strengthen, develop and appropriately fund home support services within the MidCentral District, fostering links between district nursing and other home based support services and creating a flexible responsive service.
Medium	68	Improve discharge planning for older people. Discharge planning services will be offered to all older people who are seen in the hospital emergency department including those who do not need to be admitted. Discharge planning will be part of the integrated continuum of care. Older people will not be discharged home late at night or without adequate support or medications. Institute monitoring of this.

Priority	Action	AIM 7 – Integration
Medium	69	Ensure an audit process to review re-admissions and discharge planning processes for good practice and minimisation of risks.
Medium	70	Review services to ensure age-appropriate care, treatment, coordination and integration of medical and mental health assessment treatment and rehabilitation services for older people across the MidCentral District.
Medium	71	Work with the Ministry of Health in their review of the slow-stream rehabilitation pilot project and if it is found to be successful work towards district wide implementation as an intermediate level care service.
High	72	Investigate and develop other initiatives to introduce intermediate care options for older people within the MidCentral District.
High	73	Support the district nursing service to continue to provide hospital at home care where this is an appropriate option for an older person.

AIM 8 - Flexible, timely, coordinated services

Older people with high and complex health and disability support needs will have access to flexible, timely and co-ordinated services and living options that take account of family and whanau carer needs

Priority	Action	AIM 8 – Flexible, timely, coordinated services
High	74	Work collaboratively with providers and other agencies to ensure the emphasis for provision of services for older people will be home based and to promote the development of culturally appropriate supported living options for older people.

IMPLEMENTATION OF KEY ACTIONS

The 74 key actions, prioritised as either high or medium, will be implemented over the period 1 July 2004 to 30 June 2010.

The following tables set out, in priority order, the actions that will be implemented and within what broad timeframe. Funders work within the constraints of a limited fiscal resource; the timing of implementation may therefore vary.

Actions to be implemented during 1 July 2004 – 30 June 2007

Action number	ACTION	1 July 2004 – 30 June 2007
14	Establish a sector reference group focused on and including older people to assist in identifying barriers to the implementation of the integrated model of care and advise the DHB on the best way forward.	
15	Involve local iwi, ACC, Territorial Local Authorities and other agencies in the sector reference group to ensure health promotion and coordination of services and initiatives are inclusive and appropriate for the MidCentral community.	
1	Establish a service model and fund an inter sectoral AIM information and advocacy service available to all older people of the MidCentral district and those who might assist with supporting older people.	
3	Work with providers to require services to involve older people to take the lead role in developing their own plans to meet their health and disability needs. They may be supported with this by advocacy services so that they are able to make informed choices.	
4	Work with providers to ensure that where it is appropriate there is the opportunity for family involvement in decision making.	
16	Implement the integrated model of care (AIM information service, linkages between providers, coordinated care options) and ensure associated performance indicators are developed and monitored so progress can be measured.	

Action number	ACTION	1 July 2004 – 30 June 2007
6	Enhance inter sectoral relationships through meetings and provider requirements to include information sharing in an effort to prevent, identify and reduce elder abuse.	
7	Work with providers and other agencies to increase the use of the elder abuse family violence intervention guidelines (Draft, Ministry of Health, December 2003) as a framework for assessing and intervening where abuse is suspected or identified in a timely and culturally effective way.	
10	Promote positive attitudes towards older people by requiring providers to be more responsive to older people and ensuring the DHB services model excellent behaviour in this regard.	
13	Reduce health inequalities and improve health and independence outcomes through culturally appropriate collaboration with older people, their families and communities.	
27	Increase older people's access to home support services including homecare, district nursing, respite and home help, through distribution of information, review of access criteria and appropriate funding levels.	
28	Ensure information sharing and needs assessment and service coordination with other services is improved, reducing the need for older people to have to repeat themselves unnecessarily.	
29	Require involvement of Maori, Pacific People and other ethnic community advocates in the assessment process of older people to ensure an accurate and appropriate assessment occurs.	

Action number	ACTION	1 July 2004 – 30 June 2007
31	Continue to contract Central Region Technical Advisory Service to ensure all dementia and psychogeriatric continuing care services are audited routinely and by exception as required.	
34	Complete the specialist services review and use the results to assist with future planning of services. The review will include information sharing and waiting times.	
37	Review reserved parking and disabled parking availability, quantity and location at Palmerston North Hospital for outpatient clinics and older people visiting to improve access for older people.	
38	Review transportation from rural locations to Palmerston North Hospital and establish a system that provides acceptable transportation options for older people who need to attend clinics at the hospital. This will include investigating joint district options such as the ambulance service, ACC and Territorial Local Authorities. Issues related to volunteer driver co-ordination, insurance and legal implications will form part of the review.	
39	Fund community based Maori liaison key worker position(s) to assist older Maori to access information and services and be a first point of contact if desired. Link this service to a marae based service and/or the AIM information service.	
41	Establish a field worker position(s) as part of the AIM Information and Advocacy service to work with older people at high risk of social isolation. This will include investigating intermediate care options (ie slow stream rehabilitation) and community integration introduction.	

Actions to be implemented during 1 July 2006 – 30 June 2009

Action number	ACTION	1 July 2006 – 30 June 2009
42	Continue to work with local iwi and Maori communities in planning, purchasing, delivering and monitoring culturally appropriate services for kaumatua and kuia and their whanau.	
43	Establish collocated Maori elder care and primary care services in conjunction with Primary Health Organisations - marae-based where possible.	
44	Investigate the development of home support options to specifically meet the needs of Maori and implement recommendations.	
46	Increase the involvement and ensure Maori service providers or Maori advocates participate in all needs assessments of Maori older people undertaken by the Needs Assessment Support Service.	
47	Develop and implement a plan that creates respite, convalescent and palliative care options for Maori that are culturally appropriate.	
49	Require He Korowai Oranga – Maori Health Strategy (November 2002) to be used as a framework by all providers to ensure culturally appropriate provision of care.	
50	Make AIM information services culturally appropriate and include Maori representation and Maori advocates in representation for development and management of the service.	

Action number	ACTION	1 July 2006 – 30 June 2009
56	Investigate and establish a system to identify older people at risk who would benefit from additional services and resources.	
57	Increase support to older people identified as being at risk through funding field worker and advocacy support, assisting in integration back into the community and providing any information and advice they need.	
58	Work collaboratively with other services such as primary health care organisations on initiatives AIMed at early detection of disease or disability for example vision, dental and hearing examinations.	
59	Work with the project to implement the Primary Health Care Strategy (2004) as it is complementary to this strategy. Specifically ensure , when developing PHOs, the primary care workforce is trained in health of older people.	
61	Ensure costs (fees) from providers to older people for health care are in line with legislative (ie Social Security Act) requirements. People will be informed of funding, eligibility criteria and support options available to them through the AIM Information service. Flexibility will be built into current systems where possible.	
64	Assist providers to link information systems where appropriate, with a specific focus on coordination of services so they can ensure an overview of hospital admission and return home, especially where support may be required.	
66	Ensure a continued focus in funding and planning priorities to avoid unnecessary hospital admissions – working in a wellness model of prevention and maintaining independence.	

Action number	ACTION	1 July 2006 – 30 June 2009
68	<p>Improve discharge planning for older people. Discharge planning services will be offered to all older people who are seen in the hospital emergency department including those who do not need to be admitted. Discharge planning will be part of the integrated continuum of care. Older people will not be discharged home late at night or without adequate support or medications. Institute monitoring of this.</p>	
73	<p>Support the district nursing service to continue to provide hospital at home care where this is an appropriate option for an older person.</p>	
74	<p>Work collaboratively with providers and other agencies to ensure the emphasis for provision of services for older people will be home based and to promote the development of culturally appropriate supported living options for older people.</p>	

Actions to be implemented during 1 July 2007 – 30 June 2009

Action number	ACTION	1 July 2007 – 30 June 2009
2	Encourage through suitable arrangements more timely and appropriate information sharing between providers and agencies so that information is both current and accurate. This should also reduce the need for older people to repeat themselves unnecessarily. Electronic and national information networks will be utilised where possible.	
5	Work with providers to further develop a broad multi-disciplinary approach to meeting older people's needs through improved inter sectoral relationships and information sharing.	
8	Work with providers and the wider community to establish a process to assist identified high-risk older people to meet people and maintain social networks. The AIM Information and Advocacy services will have a role in supporting this to occur.	
12	Increase home-based rehabilitation options and assistance for older people to stay at home as long as possible including, respite care options.	
21	Establish a process for training and funding that supports family members and other informal (unpaid) carers involved in providing homecare services.	

Action number	ACTION	1 July 2007 – 30 June 2009
26	Review the funding and access criteria process for home support services, dental, vision and hearing services with a view to improving access, flexibility and eligibility. Where these are national criteria work with funders and policy makers to highlight issues and assist with reviews.	
33	Ensure all providers of services meet all legislative requirements and standards in relation to providing care and support to older people with dementia through monitoring of contracts.	
36	Develop and implement an outpatient booking system that ensures timing of appointments is appropriate to older people. For example, appointments are not too early or too late in the day, multiple clinics are aligned where possible, and notification of cancellation will occur in a timely manner to avoid unnecessary travel.	
40	Develop workforce and provider skills to create a more culturally aware and skilled workforce that is cognisant and responsive to Maori culture.	
45	Provide funded training for whanau caring for older people.	
48	Review current long term living options that are available to kaumatua and kuia. If required put systems, processes and new services in place that are acceptable and culturally appropriate.	
51	Work in partnership with other agencies and providers such as the local authorities and primary health care organisations to support programmes that reduce social isolation, improve physical activity, prevent falls and improve nutritional status of older people.	

Action number	ACTION	1 July 2007 – 30 June 2009
52	Provide additional support to older people at risk of social isolation by improving social connections between older people and the wider community, through development, linking and funding of innovative community based services.	
62	Review the current provision of services delivered or available rurally ,considering access to emergency and after hours medical services. Systems will be put in place to better support rural areas that need this.	
65	Options to support older people to remain in their own home safely will be explored and implemented.	
67	Strengthen, develop and appropriately fund home support services within the MidCentral District, fostering links between district nursing and other home based support services and creating a flexible responsive service.	
69	Ensure an audit process to review re-admissions and discharge planning processes for good practice and minimisation of risks.	
71	Work with the Ministry of Health in their review of the slow-stream rehabilitation pilot project and if it is found to be successful work towards district wide implementation as an intermediate level care service.	
18	Ensure the MidCentral workforce analysis has a focus on older people to determine current and future workforce issues and requirements.	

Action number	ACTION	1 July 2007 – 30 June 2009
19	Make sure through contracts and monitoring that the training requirements and competencies of the Health and Disability Sector Standards and when mandatory, the Home and Community Health Standard, will be the minimum acceptable standards for provision of care.	
20	Identify continuing aged care educational opportunities for the community and establish an action plan to implement a programme.	
23	Invite other community groups to make submissions for the provision of services that will better meet their healthcare needs. These will be considered by the sector reference group and may be incorporated into the strategic plan.	
24	Review bi-annually the priorities in this strategic service implementation plan to ensure continued alignment of priorities to need.	
25	Require Enable New Zealand to undertake a review of delays associated with fitting of equipment and home alterations for older people and work with allied support services to put systems and processes in place to minimise delays for quality and cost effective outcomes.	
53	Coordinate facilitation of public meetings for older people through the AIM information service to address issues such as financial planning education for meeting health care needs and a wellness model for retirement.	

Action number	ACTION	1 July 2007 – 30 June 2009
55	Investigate funding options to support older people living at home who have one-off needs that can negatively impact on their health status such as the need for spring cleaning once per year. This may include working with other agencies and the local council to offer assistance with housing issues such as a lack of insulation.	
70	Review services to ensure age-appropriate care, treatment, coordination and integration of medical and mental health assessment treatment and rehabilitation services for older people across the MidCentral District.	

Actions to be implemented during 1 July 2007 – 30 June 2010

Action number	ACTION	1 July 2007 – 30 June 2010
35	Establish out-reach clinics for some specialist out-patient clinics currently undertaken at Palmerston North Hospital as collocated services throughout the MidCentral District. These services will have adequate parking and disability access.	
63	Develop a system to monitor and assess the impact of waiting times for access for older people to targeted DHB funded and delivered (hospital and health services) services. Utilise this information in future planning.	
72	Investigate and develop other initiatives to introduce intermediate care options for older people within the MidCentral District.	
9	Establish and facilitate programmes to increase community awareness of elder abuse and educate carers.	

Actions to be implemented during 1 July 2008 – 30 June 2010

Action number	ACTION	1 July 2008 – 30 June 2010
11	Invest in workforce development of carers through the development and funding of a workforce development plan that is targeted to services for older people.	
17	Ensure the MidCentral population based needs analysis has a focus on older people to assist in planning and reviewing priorities for services.	
22	Develop a health workforce of Pacific Peoples to help identify and address issues specific to Pacific Peoples.	
30	Complete a review of psychogeriatric continuing care services for the MidCentral District to ensure there are adequate resources available for the provision of services.	
32	Ensure a psychogeriatrician's review occurs in response to a patient referral in a timely manner.	
54	Work inter sectorally to address areas for public health action such as wellbeing, social isolation, smoking cessation programmes for older people.	
60	Promulgate clinical guidelines and best practice protocols for the management of common age-related health problems in primary health care setting.	

APPENDIX ONE: STRATEGIC OUTCOMES

The following outcomes for MidCentral's communities will ensue from achievement of the District Strategic Plan's vision:

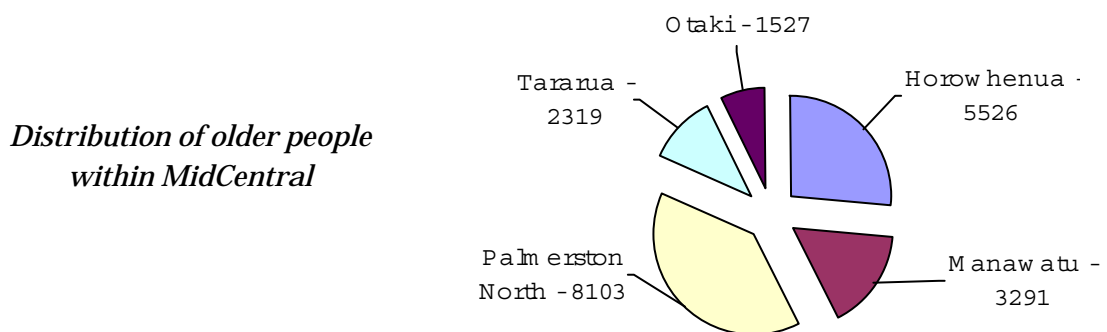
- There is community ownership and understanding of local health and disability plans and decisions
- There is user awareness of service availability, provider locations, and access procedures
- Services across the full continuum of care are being provided as close to users as possible
- Services are affordable, accessible and acceptable
- Healthy lifestyles are being achieved through health promotion and education strategies
- Primary health organisations delivering primary health care services are adequately resourced and supported
- Workforce levels throughout the district are appropriate
- Integrated planning with the local authorities and other key agencies exist
- There is coordination across the continuum of care with no gaps or duplications in service provision
- District-wide strategies and plans exist
- There is increased independence and health status due to early intervention and referral strategies
- Innovative ideas continue to provide solutions that advance MidCentral District Health Board's goals
- Support systems are in place to assist local health service provision
- The primary sector has sufficient capacity and capability to meet the needs of the district
- Services "for Maori, by Maori" are being enhanced through the transfer of specialist skills and knowledge from the secondary to primary sector

- There is a significant reduction in overall disease state due to targeted strategies for specific disease profiles
- Accountability and responsibility resides at the right level to maximise the level of services provided within available resources
- Successful primary health organisations exist
- More health and disability services are being provided within available funding.

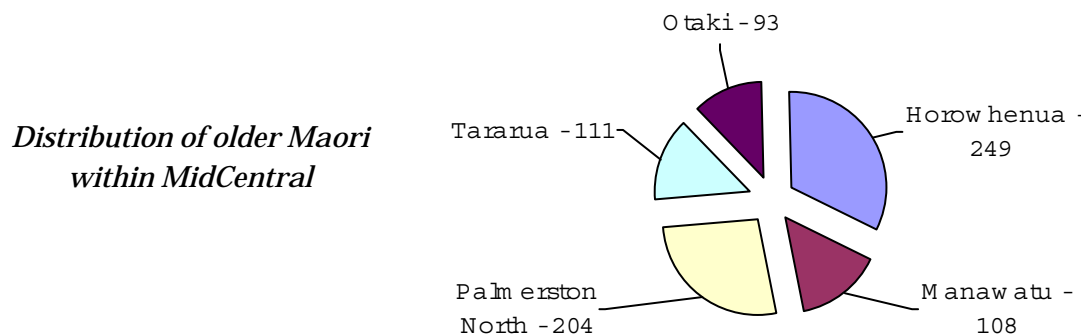
APPENDIX TWO: DEMOGRAPHIC PROFILE OF OLDER PEOPLE WITHIN MIDCENTRAL DISTRICT

MidCentral District Health Board has the 9th oldest population of all 21 District Health Board regions in New Zealand, with 13.39% (20,766 people), of the population aged 65 years or over at the 2001 census compared to 12.05% of the population of New Zealand.

The pie chart below shows the distribution of older people across MidCentral's district.



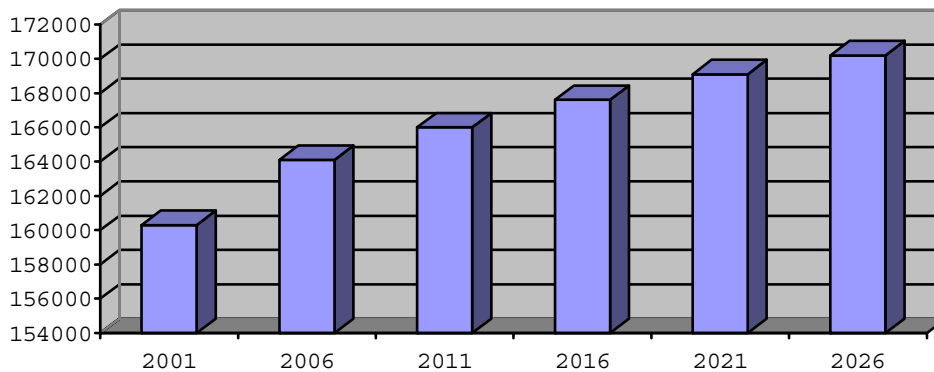
Maori aged 65 years and over account for 3.65% (765 people) of MidCentral's older person population, which is less than the New Zealand total where Maori account for 3.92% of the older person population. Maori have a shorter life expectancy than the European population, and therefore experience age-related disability and morbidity at a younger age (from 55 years onwards). The pie chart below shows the distribution of older people across MidCentral's district.



According to population projections created for the Ministry of Health by Statistics New Zealand, MidCentral's population is expected to increase by approximately 10 000 people by 2026.

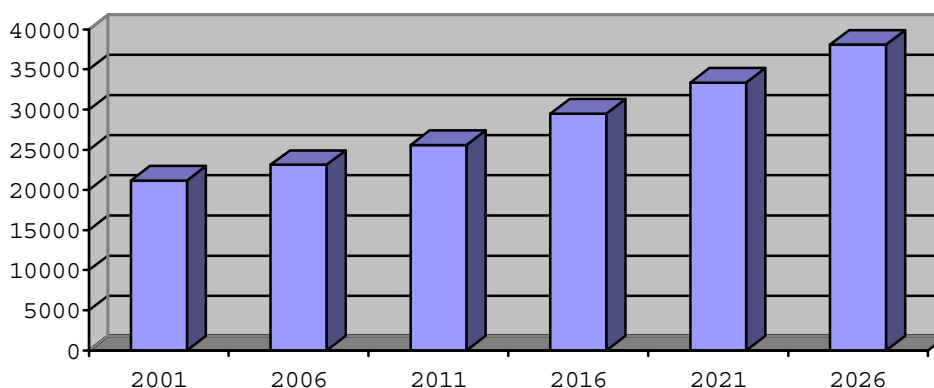
The graph below shows that by 2026 MidCentral's population growth is starting to slow, suggesting that the population may be stabilising.

MidCentral DHB population projections 2001 – 2026



However, the older population shows a different pattern. The number of people aged 65 years and over is expected to almost double in size by the year 2026. The graph below shows a steady growth rate in the older population between 2001 and 2026.

MidCentral DHB Population projections for older people (>65) 2001 - 2026



These two charts indicate that MidCentral's population increase is likely to occur from people living longer, rather than an increase in birth rate. Of the 9,900 increase between 2001 –26, those aged over 65 years account for 7,920.

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