Te Whatu Ora
Health New Zealand

Media Release

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Holistic elderly care programme expands into West Auckland

More older people will be supported to stay in their own homes for longer thanks to a newly expanded Te Whatu Ora-funded initiative led by participating general practices in parts of Auckland.

Kare is a comprehensive package offering proactive identification of health concerns and care from general practice teams that enables older patients to maintain their independence with good community support

The scheme has been operating through seven North Auckland GP practices since 2015 and has this month spread west – thanks to a generous donation from a community organisation and the fundraising efforts of Te Whatu Ora Waitematā charitable arm, Well Foundation.

Three west Auckland general practices are now running the programme - working with health sector stakeholders to provide patients with holistic support that will keep them safely in a home environment for as long as possible.

The three latest additions are funded to identify up to 260 “frail” patients within their practices over the next three years who will benefit from the scheme.

Kare is designed to improve the health of frail people aged 75 and over – as well as Māori and Pacific people aged 65 and over.

It involves:

- a comprehensive assessment of participating patients by practice nurses who then develop a care plan with the GP for regular follow-up and review
- practice nurses or GPs who follow-up with patients after discharge from hospital to ensure a smooth transition to the community
- use of a cognitive impairment tool to enable early diagnosis and improved dementia care
- support and upskilling of participating general practice teams with monthly peer review sessions with hospital-based gerontology nurse specialists.

Te Whatu Ora Kare Clinical Lead and GP Dr Diana North says the existing programme in North Auckland allows GPs and nurses to look proactively at the patient’s needs rather than reactively responding to medical problems in 15 minute appointments.

She says underlying concerns, such as reduced cognitive function, may often present as poorly managed chronic diseases, missed medications and repeat consultations. Knowledge of the patients’ broader health enables the doctors, nurses and patients to better manage their symptoms and improves access to community support services.

“This approach has resulted in patients having fewer falls, less ‘concerning pain’, a decrease in reported anxiety and depression and a better understanding of their medication,” she says.

“Subsequently, we are seeing fewer crisis visits to GP practices among this cohort, issues that arise in the ageing population are identified early and proactively managed with improved planned shared care with families and practice nurses. All of the evidence suggests this model of care is very effective at keeping people well and in their own homes a little longer than what we might have seen in the past,”

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