Te Whatu Ora
Health New Zealand

Te Tau Ihu | Nelson Marlborough

# Neurology Allied Health Practitioner - Primary Care Project

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# Abstract

**Problem:** NMDHB Neurology Service had insufficient capacity to meet demand and planned care expectations.

Models of Care programme (Ki Te Pae Ora) and consumer engagement identified protracted patient journey with lengthy waiting time for initial appointment. Whilst waiting, the impact of changes in function on a patients day to day participation in life roles and wellbeing was significant.

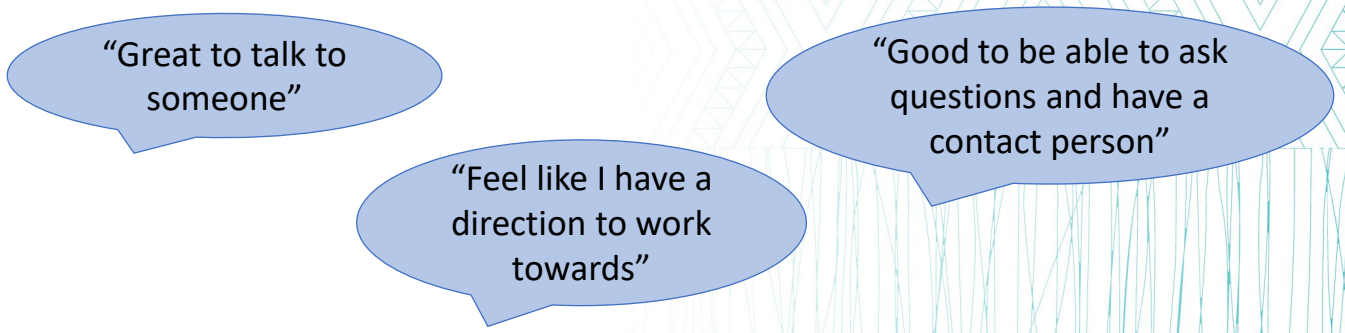
**Change idea:** 'Living well whilst waiting': ngā kiritaki hauora (patients) need access to a holistic assessment of function and needs while awaiting either formal diagnosis or the completion of diagnostic investigations.

Neurology Allied Health Practitioner (NAHP) 12 Month pilot project was established with MOH Service Improvement Project funding.

A Primary Neurology Allied Health Screen was developed and undertaken via telehealth initially, and then expanded upon in a face to face assessment. Information collected was centred around the pillars of Te Whare Tapa Whā – the four pillars of health being mental health/emotions, spiritual, physical and whānau (family). Our assessments focused on looking at home environment, cognitive assessments, physical assessment including assessment of activities of daily living, balance, gait, strength, reflexes, sensation, and connectedness, whānau and community involvement.

Based on the Allied Health screen, brief intervention was undertaken and onward referrals made to other multidisciplinary teams and support services.

# Outcomes




- **Improved patient experience:**

Patient centred care

- **Impact for Neurologists:**

Improved efficiency (1 – 2 clinic appointments per patient saved) as baseline assessment undertaken and holistic picture provided from NAHP functional assessment often in their own home.

- **Early intervention for patients:**

Patient’s referred to NAHP waited on average 7 days for contact with a health professional vs an average of 153 + days for first specialist appointment (FSA) appointment with Neurologist.

- **Timely referrals to MDT:**

Patient’s referred to MDT earlier with ability to highlight concerns for more urgent input.

# Addressing Health Inequities

- Engagement with all patients who identified as māori referred to Neurology Specialists.
- Ethnicity: Māori 13.7% Asian 4.1% European Pākehā 82.2%
- Patient and whānau centred care including joint working with Te Piki Oranga and relevant Community agencies.

**Case Study: patient who identified as māori**

- The NAHP assessment highlighted significant concerns regarding the impact of neurological symptoms on this persons day-to-day functioning, their mental health, relationships and ability to work or undertake any vocational roles. They had had a recent admission to hospital with an overdose and reported the neurological symptoms were a big contributor to their feelings of wellbeing.
- This individual's pillars of Te Whare Tapa Whā were significantly impacted upon.
- Brief intervention was provided including assessment of function, education, breathing / relaxation advice, use of adaptive equipment, liaison with Te Piki Oranga and encouragement in accessing community services. Patient highlighted and seen more urgently by Neurologist.
- Engagement and Te Taha Hinengaro (mental health and emotions) significantly improved. Self efficacy improved from 10/100 at initial contact to 80/100 at discharge from the service.

# Implementation / Translation to Practice

- **Sustainable referral pathway** for referrals to Allied Health at time of Neurology triage rather than after FSA.
- **Early Allied Health intervention** with patient and whānau is key to improving patient experience, patient outcomes and functional change in a timely manner.
- **The use of telehealth for the initial Allied Health screen** enables collection of valuable information and timely referrals to appropriate services and allows the person to be heard. Telehealth is a vital part of future health care services post COVID to enable early connection and engagement with services.
- **Health Pathways** updated to provide prompts for GP's to refer to Allied Health. Patient resources / handouts updated.
- **Current resourcing** in Allied Health does not meet patient need in order to provide this early intervention to patients. The current waitlists for Allied Health input mean individuals are waiting a significant length of time for assessment and intervention, sometimes more than 12months.
- To effectively undertake holistic, and individual focused assessments with **patients and whānau**, time needs to be invested initially to gather information. This improves ability to provide an equitable service and optimise **collaboration**.
- **Lever to support change:** Sufficient resourcing required for Allied Health disciplines.