

DEVELOP CASE MANAGEMENT PLAN (HOME-BASED CARE / COMMUNITY-BASED CARE PACKAGE)

The primary care provider is responsible for the development of such plan. To include:

- service philosophy
- activity plan according to need (refer Annexure C), to include;
 - direct or indirect supervision responsibilities;
 - comprehensive training plan;
 - relationships with other services for referrals and follow-up;
 - provisioning system to ensure availability of appropriate supplies and drugs, (Annexure D) backing of relevant knowledge and expertise around drugs, supplies and usage;
 - client and provider safety measures
- A plan for service development which is comprehensive and offering a continuum of services
- Definition of partnerships, roles, functions, responsibilities and accountabilities
- Identification of problems of concern to the community
- Identification of entry point to services and continuous, linked and uninterrupted referral system (Annexure E)
- Utilisation of coordinated community resources plan
- Medical needs component - case management guidelines
- Care component - adequate and appropriate 24-hours, 7-days a week care, quality assurance
- Support component - practical support,

e.g. information, training, resources, mentoring
(Annexure F)

- Counselling component to meet the emotional needs of the individual, family and care givers
- Spiritual/religious component to address the wide range of spiritual needs, religious beliefs, customs and feelings surrounding death, disabilities
- Social security component - legal and/or financial considerations to be addressed. Grants, pensions etc.
- Emergency services component - telephone numbers of emergency services available and known, emergency drugs, etc.
- Care giver component - recruitment, job description, comprehensive training plan and support system
- Education/training/capacity building component, for all service providers, empowerment/development plan for community and therapeutic education for clients.
- Communication component - marketing strategy, existing communication channels and structures.
- Safety component - a calling system for patients, bed rails, safe work environment, referral, reporting system of injuries.
- Monitoring, supervision and evaluation component to review budgetary needs, case management plans.
- Health information system - record keeping, collection of data, reporting system.

TRAINING AND DEVELOPMENT OF COMMUNITY PERSONNEL AND PROFESSIONAL/TECHNICAL SUPPORT/TEAM.

- Training and development policy to be in place.

- Practice codes for staff recruitment, selection, training mentoring and supervision to be developed.

Proposed list of criteria to be considered for selecting community caregivers:

Gender

Health status

Relevant skills, training formally/informally received

Willingness

Commitment and dedication

Cultural background/sensitivity

Time available

Communication skills

Location in relation to client

Previous acquired knowledge

Interest

Previous experience in providing care

Reliability

Honesty

Respect for confidentiality/privacy

Literacy

Financial status

Understanding of concepts in relation to home-based care

- Designated mentor for care givers to be selected
- **Training coordinator** to be selected from any suitable group
- Resources for training and empowerment to be identified and budgeted for
- Select training supervisors from the different groups
- Develop training programme from preventative to

- rehabilitation and palliative care, including -
- involvement of all levels of care;
 - client-centered and holistic approach;
 - community-centered approach;
 - principles of adolescent and adult education;
 - utilise community experience and knowledge;
 - simple principles;
 - practical guidelines for disease management, counselling and prevention - cultural and economic sensitive
- Guarantee availability of essential and appropriate training materials, equipment, supplies and personnel
 - Training should take place at all levels, following approved guidelines, standards of practice and language of choice.
 - Content of training will be determined by the needs, role and responsibility of caregivers.
 - Training should be based on needs and be flexible to allow for individual adjustment

INTEGRATION INTO THE DISTRICT HEALTH SYSTEM (DECENTRALISATION)

- Marketing of the programme, active involvement of the community leaders and management teams
- Respect consumers and their families' wishes and objectives for care
- Mass communication strategy including sharing of information, advocacy and lobbying through leaders, decision-makers, others.
- Building partnerships, through
 - productive dialogue;
 - shared vision and goals;

- preparedness to work together, e.g. community development forums, management committee;
- sharing/pooling resources.
- utilisation and sharing of skills
- Contracting with clients, services and families
- Shifting of resources and power to primary level
- Transfer and expand beneficial projects

MODELS (There are many)

Select best practice model in South Africa

IMPLEMENTATION

Develop implementation plan with active involvement of consumer, partners and all relevant stakeholders at an early stage to include:

- service philosophy and objectives;
- support services/systems for existing services and roleplayers;
- responsibilities and accountabilities as per roleplayers;
- priorities and direction for service provision;
- recording, reporting and follow-up system;
- guidelines, protocols and procedures to guide client on a continuum of care;
- emergency services and safety protocols;
- provisioning system for equipment and supplies at the most easily accessible point;
- an integrated caregiver programme (this will be the family in most cases);
- evaluation process to monitor programme outcome expectations;

- service care plan to address the availability of 24-hours, 7-days a week home support with ability for quick response. Accessibility to acute care services, respite care or personal care at home is essential;
- identification system of those families in need of regular follow-up; and
- referral system.

EVALUATION OF HOME-BASED CARE AND COMMUNITY-BASED CARE

Develop evaluation strategy to:

- include tools to be used for evaluation and monitoring;
- fit within an overall framework;
- involve those persons participating in the provision of service (e.g. the individuals, their families, interdisciplinary care providers, volunteers and organisations);
- ensure ongoing monitoring;
- ensure ongoing needs assessment and adjustment of all plans;
- monitor the evaluation process, to ensure the quality, appropriateness and effectiveness of all services;
- determine if the service is meeting the outcome expectations;
- establish a dissemination, follow-up and feed back system for information.

The recommendations derived from the evaluation process is an essential component in the development process and in the provisioning of on-going care.

Develop indicators to measure:

- Professional conduct
- Minimum service standards
- Structure standards
- Process and
- Outcome standards (value added)
- Appropriateness: does the programme as a whole respond to the main health needs of the target population?
- Acceptability: are the services provided in a manner that is acceptable to the target population and encourages their appropriate utilisation?
- Accessibility: are the services provided so that the problems of access to build environment, information, health professionals, drugs and supplies, assistive devices are minimised and equity is promoted?
- Effectiveness: do the services provide satisfactory outcomes both from the clinician's/health care provider's point of view and that of the users and their families?
- Efficiency: are the elements of the programme provided so that the maximum output is obtained from the resources expended and does the mix of services represent the best value for money with regard to the health needs of the population?
- Equity: are the needs of different sections of the target population met in a fair and just fashion?