Imagine...

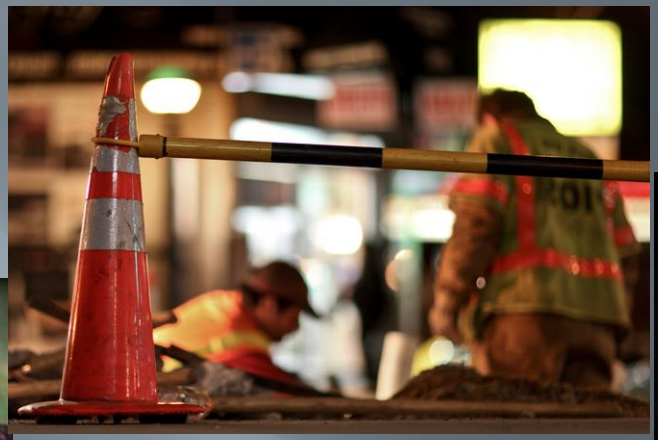
Your weekend plans: bike, golf, DIY, travel, time with family, sport

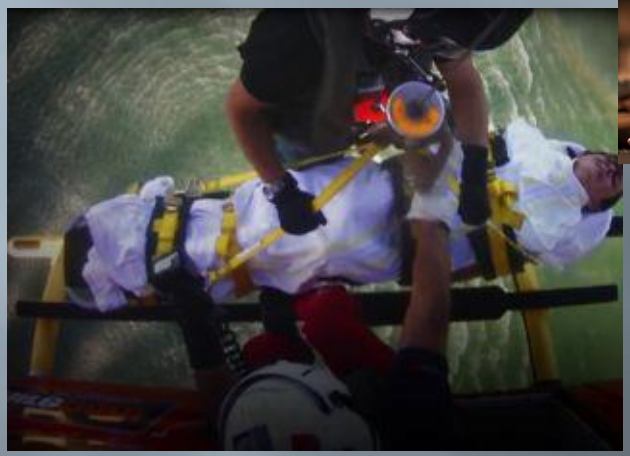
Your professional plans: continued learning, teaching, working, retirement

The freedom: of sleeping in or getting up early to go for a run; or of reaching for your partner

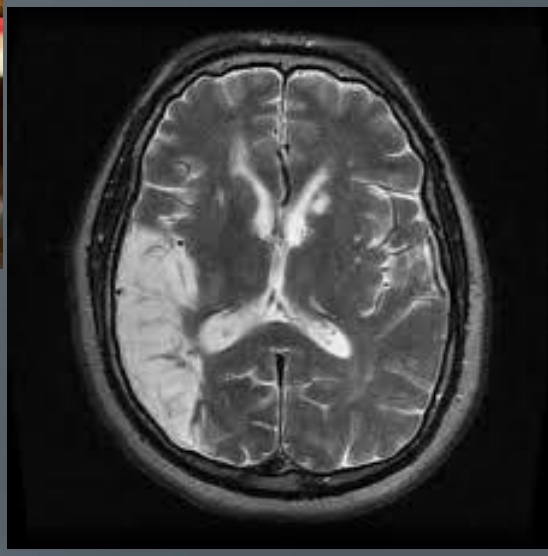
Imagine how, in an instant…

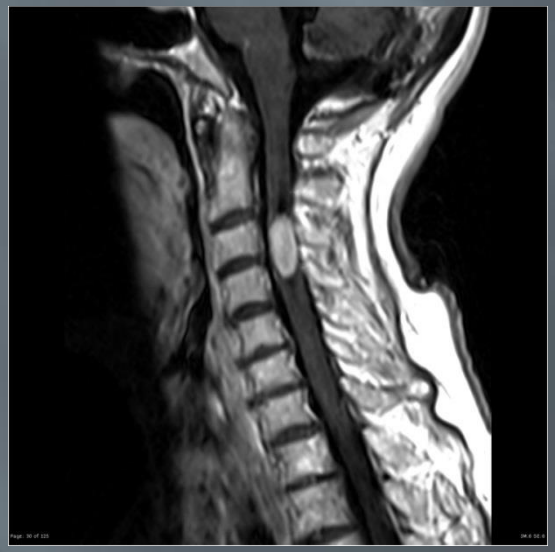
Injury

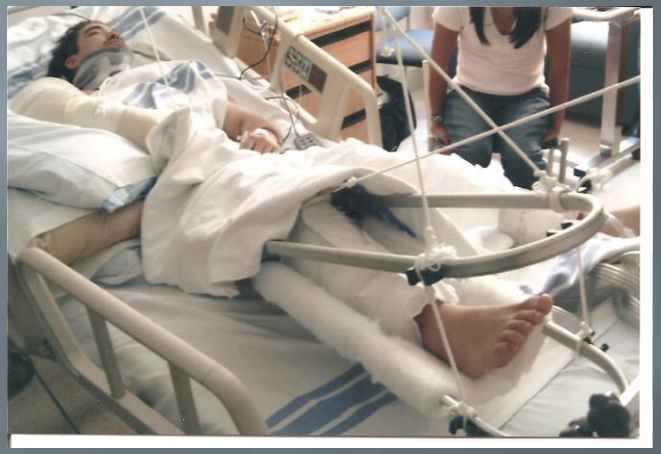




Diagnosis







All those plans – big and small, for today and the future – can change

Specialist Rehabilitation provides:

- a comprehensive, interdisciplinary and biopsychosocial service
- directed by Rehabilitation Medicine specialist physician
- aimed at enabling people with short term or long term loss of health, function or ability due to injury or illness
- to reach and maintain their optimal physical, sensory, intellectual, psychological and social abilities
- in order to live a meaningful live.

A Specialist Rehabilitation Medicine Service is an
evidence-based,
person-centred,
goal-oriented service
developed through **service user co-design**
providing skilled **IDT** interventions .

4 Aspects of Rehabilitation

1. Promote recovery and functional return; maintain hope.

2. Optimise independence & ability to direct care; return to life roles.

3. Identify home, equipment and care support needs.

.

4. Educate individual & family to prevent 2º complications in anticipation of future opportunities & to ensure high Quality of Life.

WHO International Classification of Function (ICF)

IMPAIRMENT

Alteration in Body Function / Body Structure

- *physiological* functions of body systems (including psychological function).
- *anatomical* parts of the body (organs, limbs)

ACTIVITY

Activity is the execution of a task or action by an individual.

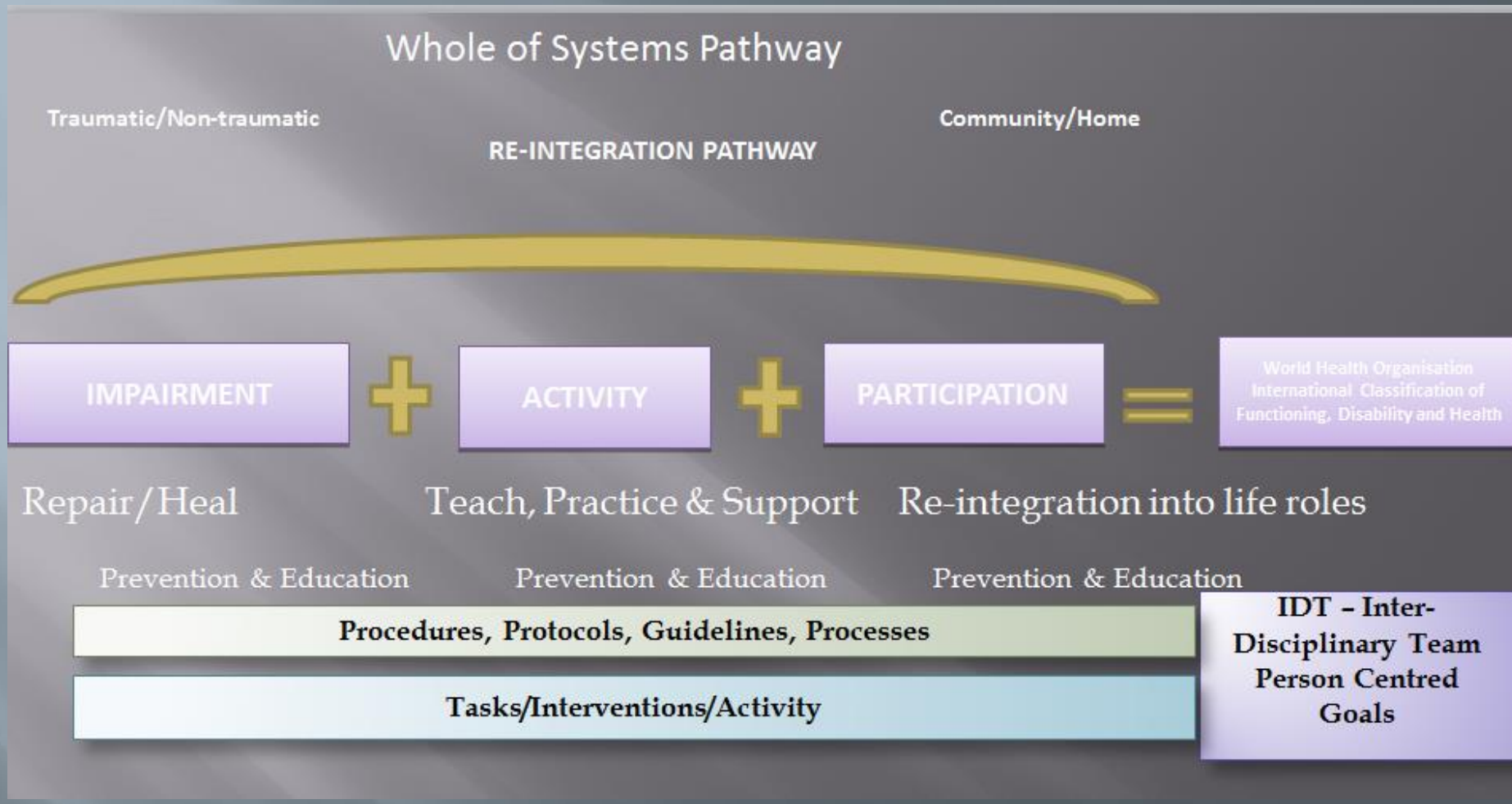
- **Activity Limitations** (previously described as **'*disability*'**) are difficulties an individual may have in performing basic daily activities *due to the impairment*.
- **Basic ADL**

PARTICIPATION

Participation is involvement in a life situation / life experience.

- **Participation Restrictions** (previously described as '***handicap***') are difficulties an individual may experience in life situations due to the environment.
- **Environmental Factors - consist of** the physical, social and **attitudinal** environment.
- **Industrial ADL**

"Disability" & "Handicap" are not within the person but are within the environment and the environment's restrictions upon the person.


Whole of Systems Pathway
Traumatic/Non-traumatic
Community/Home
RE-INTEGRATION PATHWAY
IMPAIRMENT
ACTIVITY
PARTICIPATION
World Health Organisation International Classification of Functioning, Disability and Health
Repair/Heal
Teach, Practice & Support
Re-integration into life roles
Prevention & Education
Prevention & Education
Prevention & Education
Procedures, Protocols, Guidelines, Processes
Tasks/Interventions/Activity
IDT – Inter-Disciplinary Team Person Centred Goals

C Bennett

1993: THE WHO GENERAL ASSEMBLY ADOPTED STANDARD RULES ON THE *EQUALIZATION OF OPPORTUNITIES* FOR PERSONS WITH DISABILITIES.

30 March *2007*: New Zealand with 81 other countries recognising the

importance of rehabilitation

signed the U.N. Convention on the Rights of Persons with Disabilities.

The Convention identifies

Rehabilitation as a

Human Right.

Standards Inclusive of All Aspects of Rehabilitation

In particular:

- co-design of rehabilitation service programmes
- individual & family involvement in treatment plans

"Nothing about me without me."

HOLISTIC, PERSON CENTRED APPROACH TO:

Recovery
Rehabilitation
Reintegration

Principles of Occupational Medicine Rehabilitation Medicine

- Holistic : mental & physical well-being
- Purpose: optimise function
- Person centred & goal oriented
- Skilled team interventions
- Whole of System (WOS) approach: prevention, assessment, diagnosis, management, recovery, rehabilitation, reintegration

Unique Medical Specialties

- **OM**: mental, medical & physical well-being addressing prevention & work related injury or illness
- Person centred / goal oriented programme
- Optimising environment & function for job safety & performance
- Skilled Multidisciplinary Team
- Whole of System (WOS) Service: work place & job related health & well-being, prevention of injury/disability, assessment, diagnosis, management, recovery, rehabilitation, work reintegration

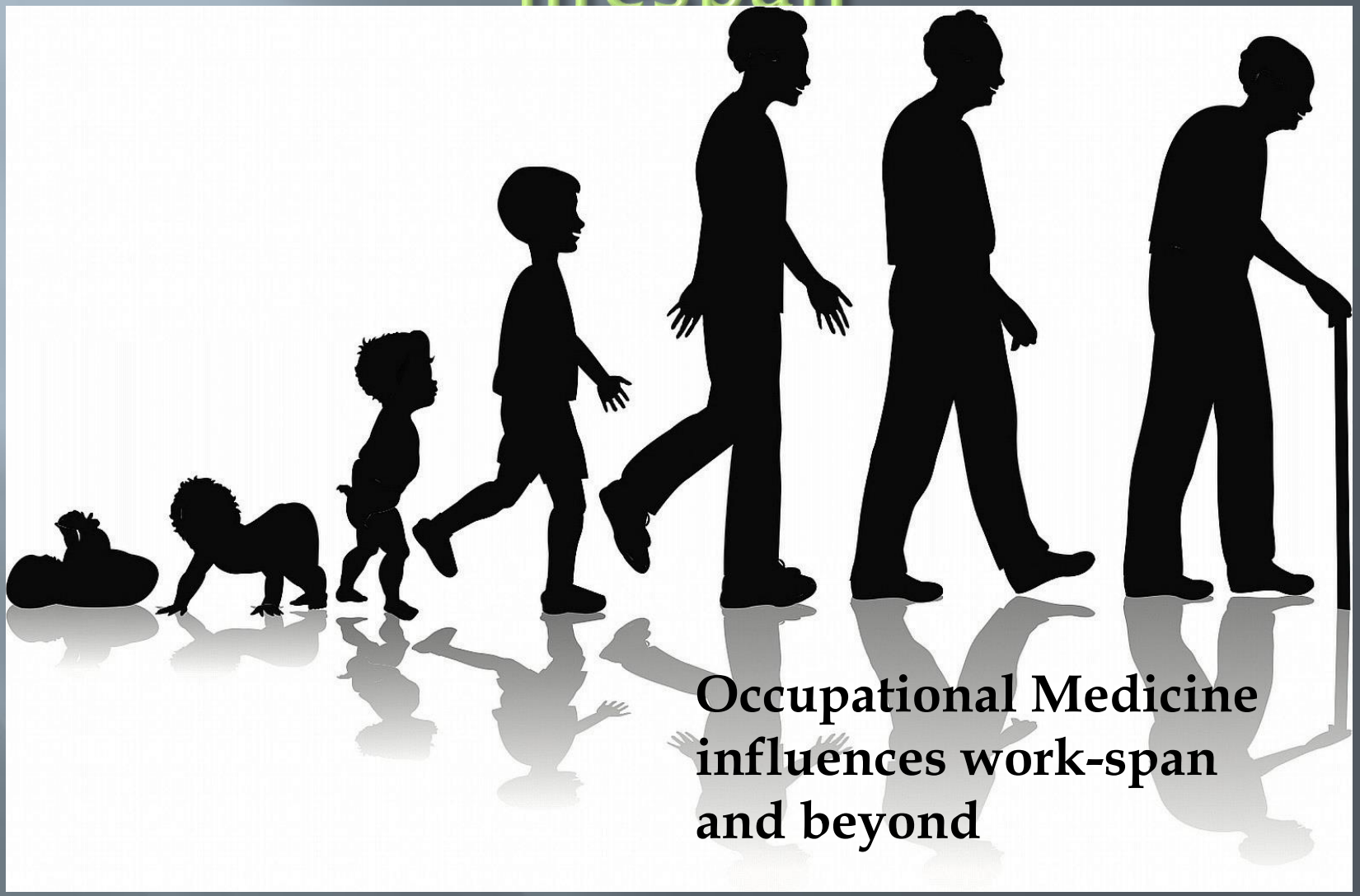
- **RM**: mental, medical, physical & psychosocial well-being addressing prevention & all body systems & functions
- Person centred / goal oriented programme
- Optimising environment & function for ADL & participation in life roles
- Skilled Interdisciplinary Team
- Whole of System (WOS) Service: health & wellbeing, prevention of injury/disability and 2° complications, assessment, diagnosis, management, recovery, rehabilitation, life reintegration

OCCUPATIONAL MEDICINE PHYSICIAN

Through knowledge of worksite operations ensures employers identify areas of risk to worker & client health & safety;

- Evaluates the interaction between work and health;
- Is responsible for employee health through prevention & management of work related illness and injury with supported RTW

Rehabilitation across the lifespan



WHAT IS PERSON-CENTRED REHAB?

COLLABORATION OF EXPERIENCES

- **Directed** by the person who has the experience
- **Guided** by the people who have lived through the experience (co-design)
- **Supported** by the people who have the clinical experience

PERSON-CENTRED; GOAL ORIENTED

In other words, goals, treatment & plan are developed and actioned WITH the individual not done TO the individual.

GOALS are the person's -

medical and therapy treatments consist of the supports/steps /tasks needed to attain those goals.

Individualised Rehabilitation Plan

- *Ensures relevance of & engagement in rehabilitation*
- *Enables full participation by the individual encouraging ownership & responsibility for their outcomes … their future*

ALTHOUGH WE KNOW *HOW* TO DECREASE DISABILITY

New Zealand's Limited **Public** Healthcare Resources do not adequately support the recognised need for Physical Rehabilitation or Vocational Rehabilitation

Rehabilitation Medicine is Not Recognised as an Integral Component of Health & Well-being

The Focus continues to be on separate "Health" and "Disability" Strategies

"Health & Ability Strategy"

Disability in NZ

NEW ZEALAND CENSUS 2006

~ 660,300 New Zealanders 1+ 'disability'

17% of the total population

NEW ZEALAND CENSUS 2013

~ 1,062,000 New Zealanders 1+ 'disability'

24% of the total population

2013

3rd leading cause of adult impairment due to "**natural ageing**"

Disability Disparity - Maori & Pasifika

- Māori experience higher rates of disability (21%) vs non-Māori (16.7%).

- **~43,000 Pacific adults** identified as experiencing 1+ disability (2006~24,300); 42% due to injury

- **>50%** of disabled Pacific people **< 45 years**

Disability Disparity - Financial

Disabled New Zealanders - low socio-economic status:

- live on their own and *more likely to live in households with low incomes,*
- *less likely to have educational qualifications*
- *less likely to be in the workforce*

'Cost of disability' research study in 2010:

- ***Additional*** costs for a single person with disability living alone ~ $200 → $2,500/week, depending on the impairment type and level of need.

Societal Cost of Disability:

- Lost: income/tax revenue;
- Social: burden on family/society;
- Benefit of work; national productivity

REHABILITATION DECREASES THE EFFECTS OF 'DISABILITY' …. HOWEVER … ACCESSIBILITY TO THE 'HUMAN RIGHT' IS SEVERELY LIMITED IN NZ

Due to inequities related to:

Funding -

Aetiology

Age

Location

Inequity due to funding

- Adults living with disability in New Zealand supported ~ by three funding systems (ACC, MOH, DHB) – dependent upon
  - aetiology (accident vs illness);
  - whether a short-term or long-term condition; and
  - age.

- "This funding model for rehabilitation services has been criticised as an **obstacle** to a comprehensive rehabilitation system." (WHO report on NZ rehab)

Inequity Due to Aetiology

MINISTRY – ILLNESS/CONDITION

- Limited personal/family/household supports
- No psychological support
- Limited, very **basic equipment**
- Limited personal supplies
- **~No home modifications (ramp)**
- Income testing for PH
- **Self-funded driving assessment, vehicle purchase & modifications**
- **No Vocational Rehabilitation**
- Limited DHB therapy

ACC - ACCIDENT/INJURY

- 24h+ care in home
- Personal, household & family support
- Psychological support
- Equipment & home modifications
- Medications & personal supplies
- Interim accommodation or PH
- Vehicle, driving assessment, vehicle modifications
- Vocational Rehabilitation RTW
- On-going private therapy

Inequity due to age < 65 >

< 65 MOH

DHB

- Generally no rehab unless in Geriatric AT&R ward
- Limited personal/household supports; multiple needs assessors w/o delegated authority & within limited budget
- Short –term disability supports: Physical, sensory & ID **dx before 18**
- Long-term supports:
  - **DSS** (physical disability & cognitive incl dementia - Alzheimer's, EtOH)
  - **LTS CHC** (health related – no physical/mental "disability")
- Accommodation ~ **no housing mods; no age-appropriate residential care facilities**
- **No Voc Rehab**
- **Family/social & financial disruption**
- **Living longer with disability**

MOH 65+

MOH

- AT&R rehab units in DHBs
- One NASC
- Equipment & home modifications from NASC delegated authority to identify care package, equipment & mods – no max

INEQUITY DUE TO LOCATION

4 / 20 DHBs - Rehab Medicine Specialists [AFRM(RACP)] & AFRM accredited rehab units

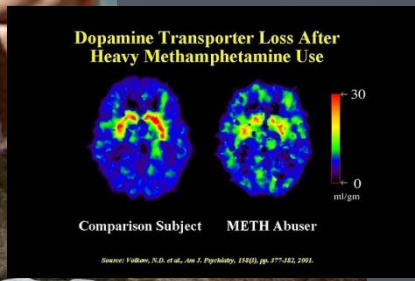
DHBs AT&R " **>65** " Wards with Geriatrician, AH, nursing, SW teams

DHBs Developing Community Rehab Services

Post-Specialised Rehabilitation (non-ACC → home DHB OP services

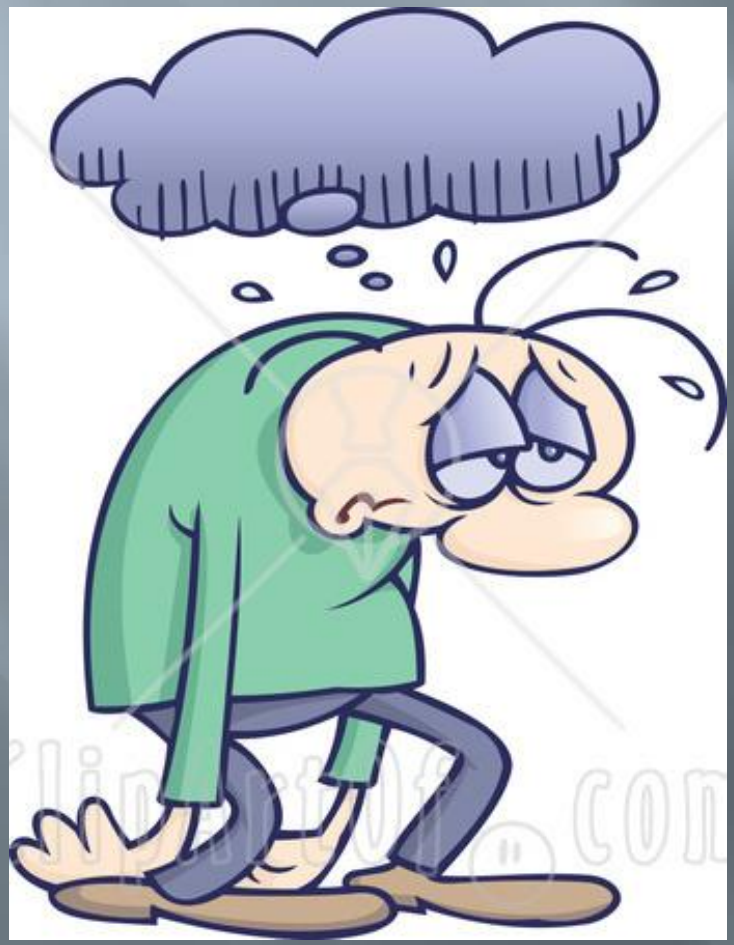
- poor equipment provision
- very limited home modification
- limited skill therapists (AT&R)

Stroke < 65 NZ



Ageing

Not ALL Doom & Gloom…



WE CAN
DECREASE EFFECTS OF DISABILITY IN NZ

- **Collaborate**: stakeholders, people living with disability, rehabilitation & occupational medicine specialists, healthcare providers, funders
- **Think**: Coordination of services /Multidisciplinary care
- **Talk**: $$$ to MoH re: numerous inequities & need for social investment & change
- **Advocate**: inclusion of rehabilitation & rehab principles in all aspects of healthcare: **"Health & Ability Strategy"**
- **Create**: return to work opportunities and incentives; remove barriers, disincentives & risks
- **Recognise, support and grow**: Rehabilitation Medicine & Occupational Medicine Specialties in NZ

CALL FOR A NEW ZEALAND REHABILITATION STRATEGY

*Guide ***government policy and practice of healthcare*** WITH & FOR those with disability through Co-design

Improve the health, wellbeing, functional abilities and thus participation of New Zealanders who experience disability from illness or injury.

Enhance functional ability / independence
reduce the individual, Whānau/family and societal burden of disability.

Improve access to & participation in the community and workplace to provide opportunity to contribute to family, the community and the economy by return to life roles and work force participation.

Lessons from OM & RM

- Co-designed, WOS services based on WHO ICF
- Individualised, person-centred programme "Nothing about me without me."
- Person-centred Goals – meaningful to the individual; the MDT/IDT provides the skill, encouragement & learning of 'tasks' needed to support the person in achieving their goals.
- OM & RM opportunity for collaborative & integrative case management to decrease the risk of and the effects of disability.

REHABILITATION ALLOWS THOSE WHOSE LIVES HAVE BEEN SAVED BY SKILLED EMERGENCY CARE AND ACUTE MEDICAL AND SURGICAL CARE – *TO REGAIN A LIFE WORTH LIVING.*