

Integration

Are we there yet?

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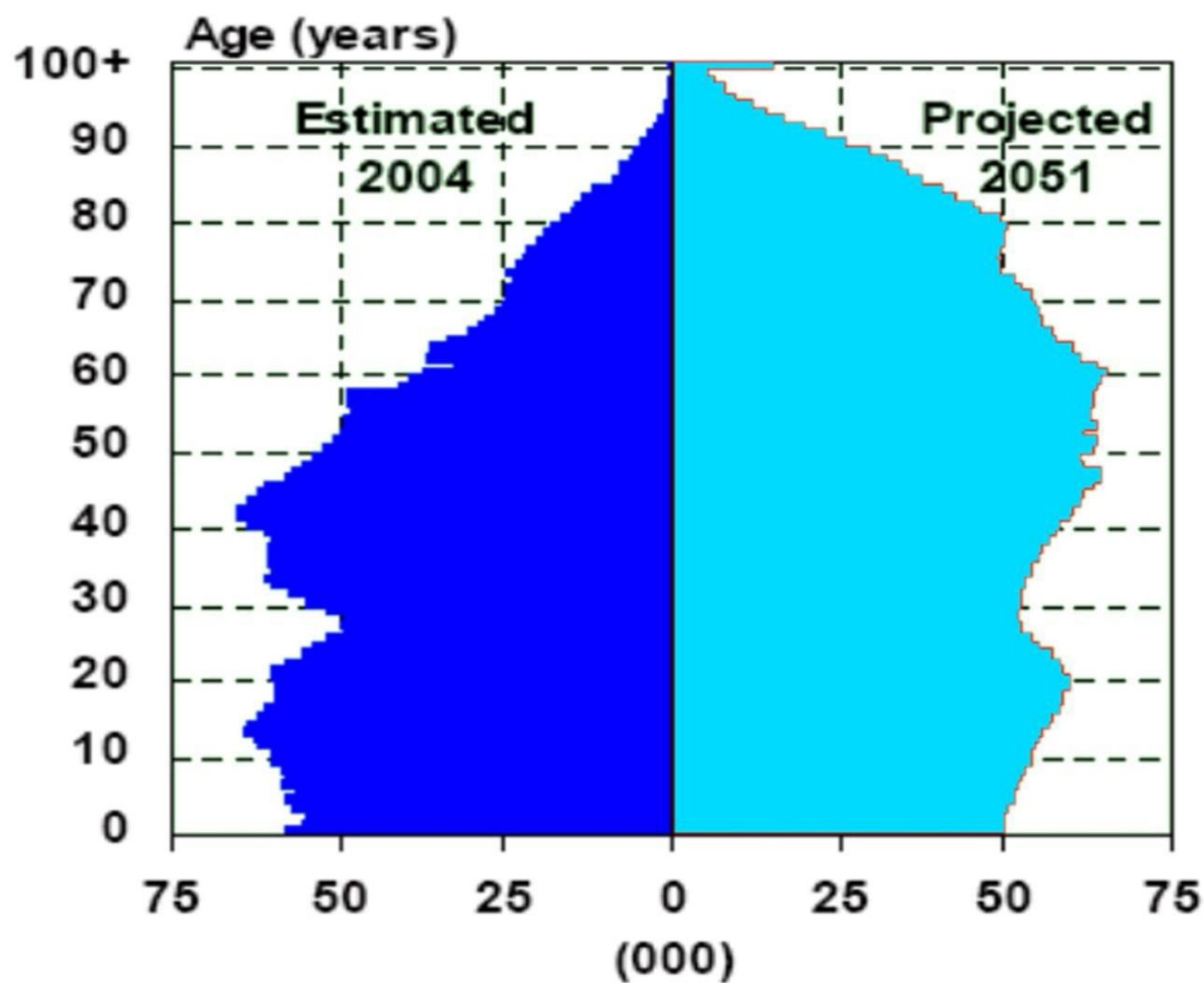


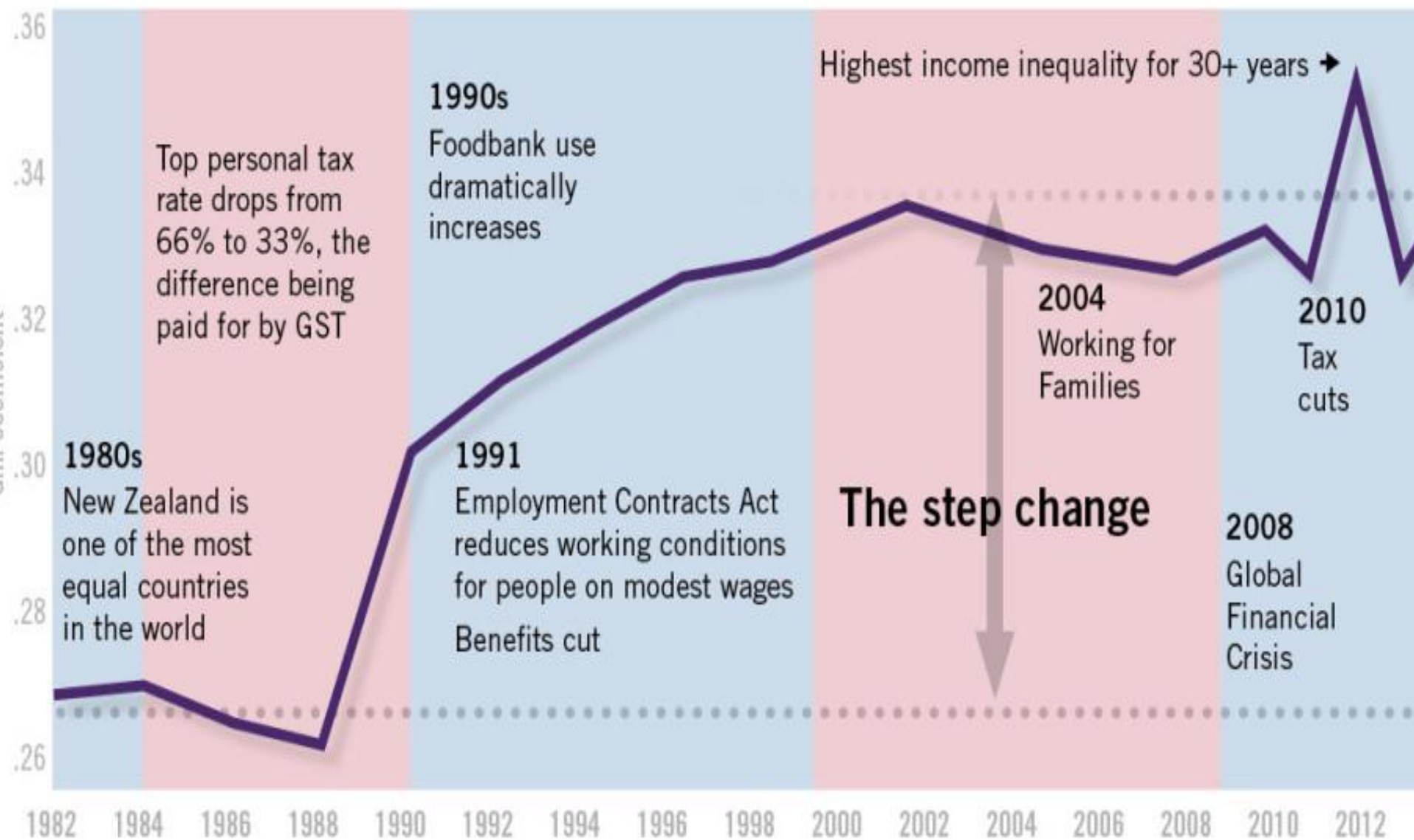
How do we know we need to?



“Today, more than 95% of all chronic disease is caused by food choice, toxic food ingredients, nutritional deficiencies and lack of physical exercise.”







*The Gini index represents the spread of incomes in a country. In a country with a Gini index of 0, everyone would receive an equal income. In a country with a Gini index of 1, just one person would receive all the income. Data source: BHC-1, Table D.9, Perry (2014), Household Incomes in New Zealand, Ministry of Social Development



- The Horn Report- 2009
 - Sustainability of health sector under threat
 - DHB duplication
 - Fragmentation of services
 - 170 recommendations



The current paradigm

When enough anomalies are recognised in the current paradigm, it will exist in a state of crisis - and even conflict - until a new paradigm emerges

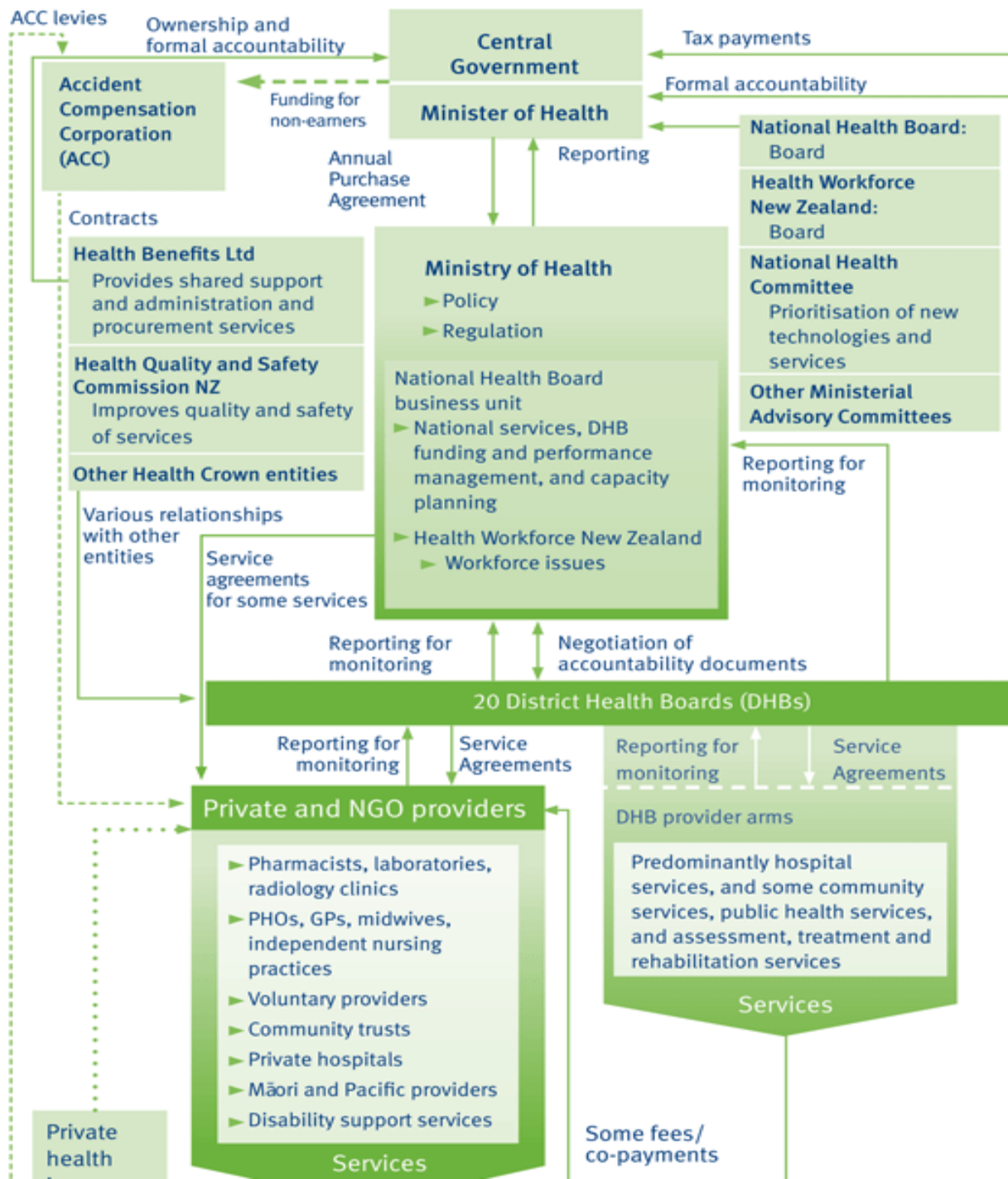
J. Cummings: Integrated Care in NZ

Int J Integr Care. 2011 Jan-Dec; 11

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC322601>

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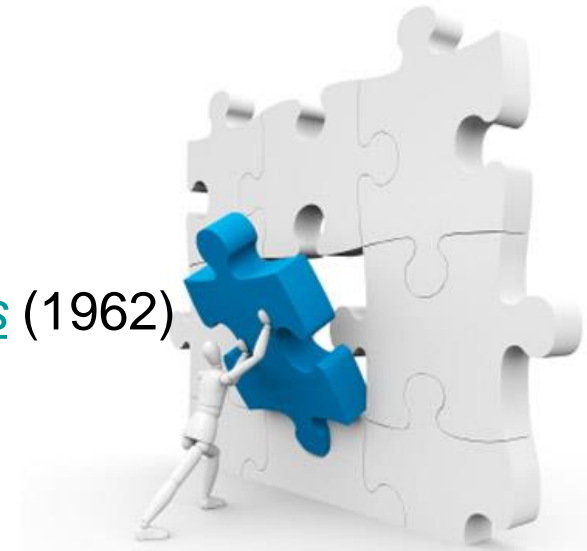




Emerging paradigm

An intellectual "battle" takes place between the followers of the new paradigm and the hold-outs of the old paradigm.

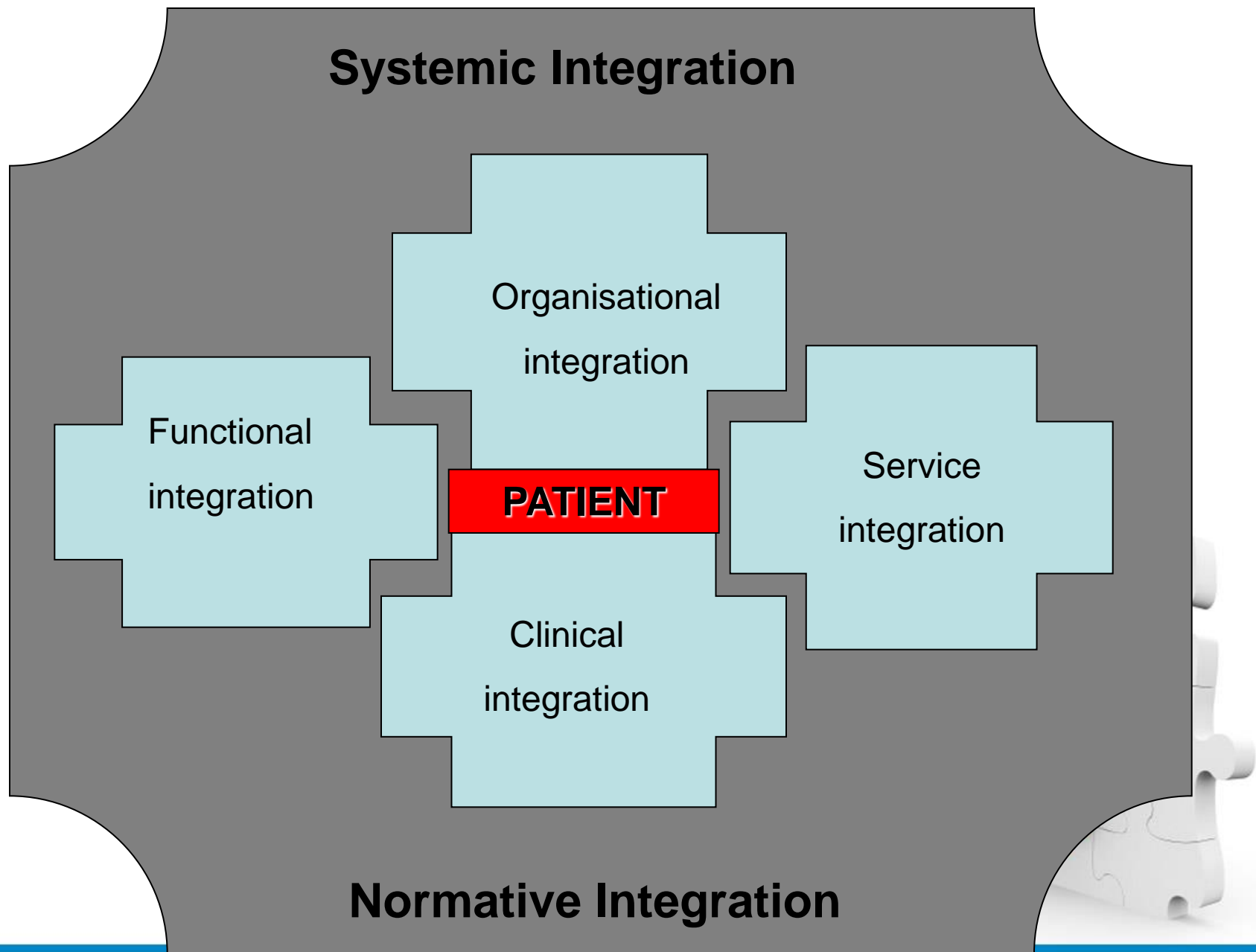
Kuhn, T [The Structure of Scientific Revolutions](#) (1962)



Integrated Care

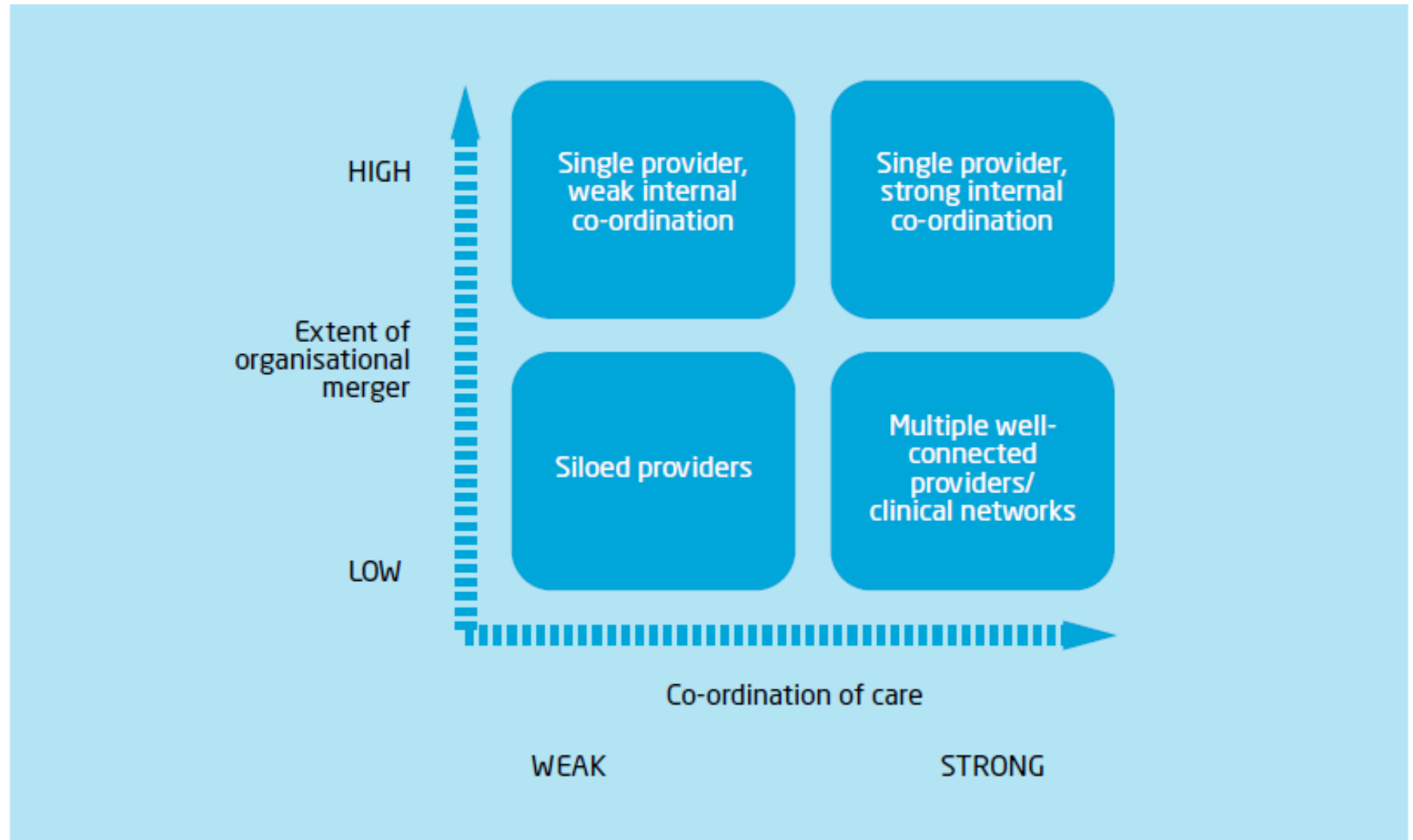
“a relentless focus on the needs of the patient”





Source: Fulop et al. (2005), adapted from Contandriopoulos et al. (2001)

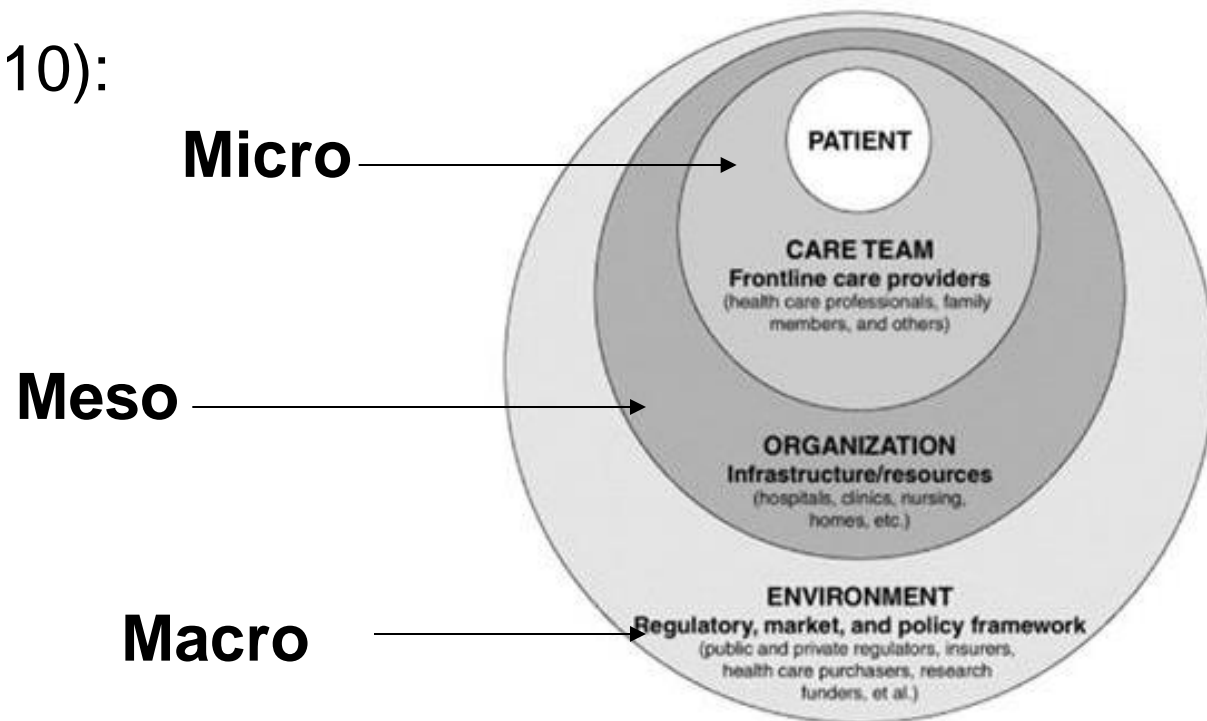
Figure 2 Conceptualisation of integrated care in terms of organisational form (from Donaldson in Ham and de Silva 2009)



Integrated Care Systems

Integration may be implemented at different levels:

(Curry and Ham 2010):



Macro level- high level systems

Characteristics:

Multispecialty medical groups

Aligned financial incentives- eg avoiding perverse incentives

Use of guidelines and best practice evidence

Registered population to facilitate continuity of care

Robust quality programmes utilising data from all health professionals

Effective leadership with a focus on CQI

Collaborative culture focusing on teamwork with patient centred care



Meso level focuses on the needs of particular groups of patients and populations with the same condition

Characteristics:

- Organised provider networks with service agreements, joint training, shared information systems
- Redesign of care pathways
- Case management multidisciplinary team care with single point of contact



Micro level



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Micro level focuses on improve care co-ordination
for individual patients and carers

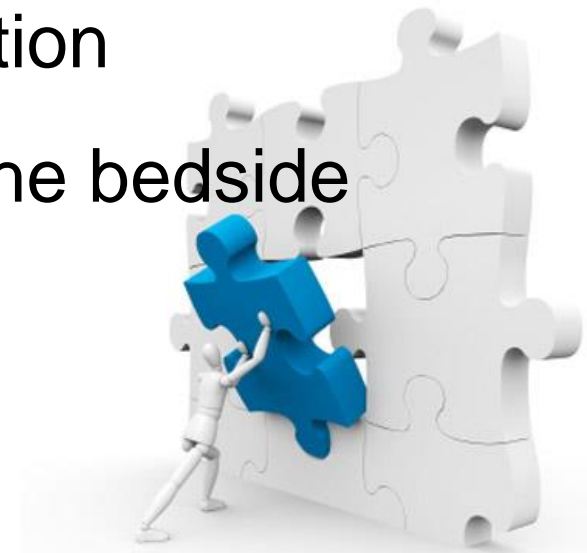
Characteristics:

Patient centred medical homes

Utilises care management/co-ordination

Use of technology- IT, telehealth at the bedside

Electronic health care record

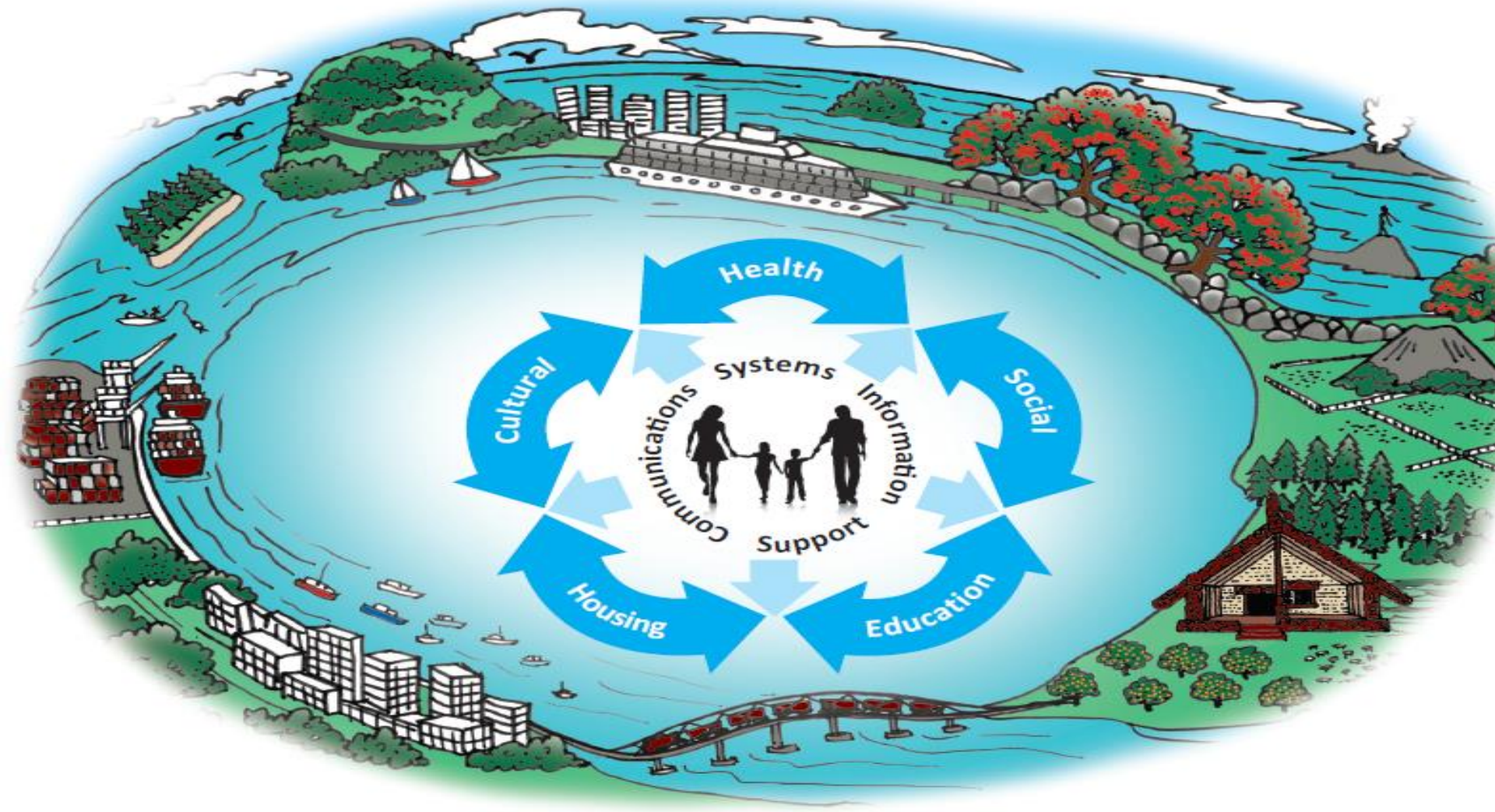


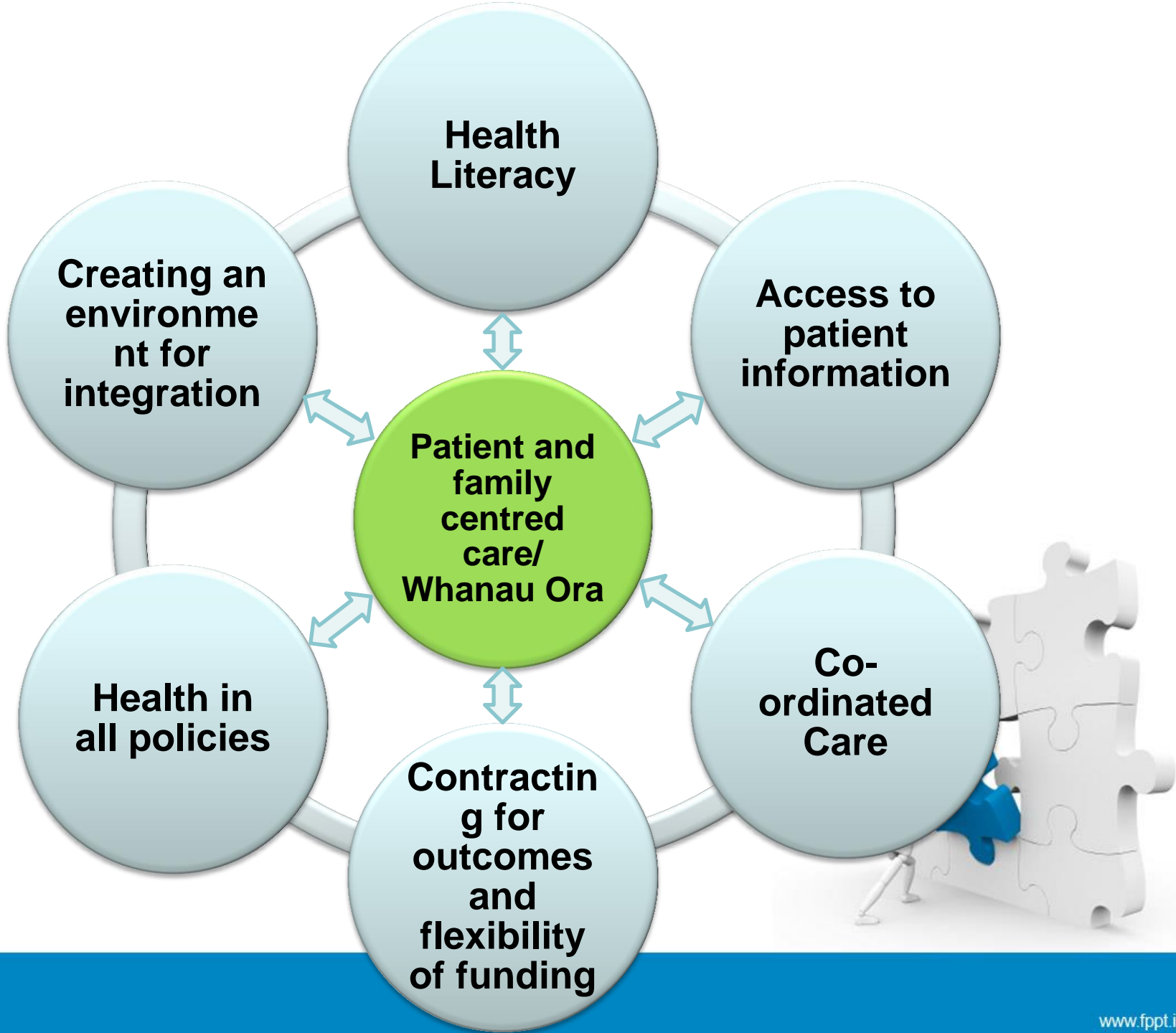
Are we there yet??

- MoH – funding streams- DHBs more responsible for PHC
- DHBs- DAPs
- ALTS/SALTS
- IPIF instead of PPP:
 - Heart checks, cervical screening
 - Immunisation rates
 - Smoking cessation rates



Bay of Plenty example





HEALTH CARE REFORM



**So where
are the
nurses and
consumers
at the
table?**





Moving
from this
attitude..



RELAX... WE'RE ALL CRAZY...



IT'S NOT A COMPETITION

memegenerator.net

Towards
acceptance
of
differences





Don't Worry Little

Buddy I've got your back!

To not just
collaborative
but also
supportive
practice



What will DHBs do?

Assume greater responsibility and accountability for integration **AND**

for Primary Care performance

Form Alliance agreements with PHOs that includes use of the flexible funding pool

Develop specific areas of their DAPs with PHOs

DHBs will develop system wide service configuration changes in collaboration with PHOs



What about PHOs?

- Same as before or different?
 - Better communications with other PHOs
 - More integrated teamwork with DHBs
 - Inclusion of **all** health providers
 - Better inclusion of consumer “voice”



Sometimes you just have to put on
your big girl panties and deal with
it..



And
nursing?



Case Study

- Sally is a 76 year old woman who was sent to the ED from the general practice with a UTI and dehydration.
- She lives alone, no family as a spinster
- Has a regular carer
- Still driving
- IHD, CCF- mild cardiomegaly
osteoporosis



Case Study

- Discharged on a Friday without seeing older adult liaison nurse
- No discharge summary 4 days later
- No carer for first 2 days
- Undiagnosed delirium
- Diuretic reduced, started foscarnet,
- Given different brand of beta blocker



Case Study

- Rang hospital for discharge summary
- Telephone call and home visit:
 - Assessment of CCF, delirium, falls risk
 - Called carer to confirm she was returning
 - Called pharmacy to confirm correct medications and initiate blister pack
 - Cleaned out bathroom cabinet
 - Made appointment with GP for review
 - Completed MOCA to assess level of cognition
 - Enlisted help of neighbour as a watching friend
 - Initiated process for medical alarm

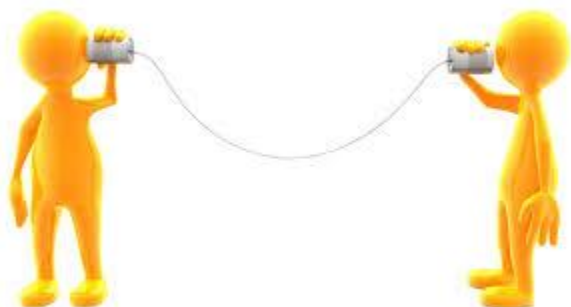




**Sometimes we just need to
change our perspective...**



Solutions...



CLINICAL LEADERS

Conclusion

He tawhiti ke to koutou haerenga

Ki te kore e haere tonu

He tino nui rawa o koutou mahi

Kia kore e mahi nui tonu

*We have come to far not to go further, we
have done too much
not to do more.....*

