Community Nursing – influencing the health of our communities – a perspective from Counties Manukau our journey towards integration

Karyn Sangster
Chief Nurse Advisor Primary and Integrated Care
Counties Manukau Health
Counties Manukau

Population Profile

- 62% of the Counties Manukau population are Māori, Pacific or Asian.
- 36% of residents live in areas of high socio-economic deprivation.
- 30% of children in Counties Manukau live in crowded households.
- 24% of the population is aged 14 or under.
- The local population aged 65 and over is the fastest growing in New Zealand.
- 44% of children in Counties Manukau live in areas of high socio-economic deprivation.
Need for change

Weekly EC Presentations by Calendar Year

Presentations

Week
Healthy Together Strategy

‘Healthy Together’ outlines what we want to achieve for the people of Counties Manukau and how we will measure that achievement over the next 5 years. This strategy builds on our past successes and strong performance to:

• Provide high quality and high performing modern specialist and hospital based services

• Strengthen primary and community based services to reduce the burden of disease and prevent ill health

• Achieve health improvement for all – with targeted support for our most vulnerable people and communities.
Challenges

- Capacity
- Capability
- Change management
- Organisational support PHO/DHB
Guiding Principles for Transformation

• Change needs to be led with the patient at the centre
• Strong clinical leadership
• People must connect with the benefits, reasons and vision for the change
• The culture and practice of testing, measuring and ongoing learning is critical
• Organisational change - attention and focus with changes carefully phased
• Strong quality improvement focus must be embedded
• Equipping and enabling the workforce
“I don’t believe the current model of general practice, based on 10-15 min appointments where the GP sees everyone, is sustainable. We need to have an approach whereby you give a proportionate response to a person’s health care needs. They still have a personal doctor and access to a personal doctor but that doctor is no longer working on their own. He or she is working with a team of people that responds to patients in a proportionate and coordinated manner.”

Dr Tim Hou of Mangere Health Centre.
Enablers:
- Dynamic pathways
- Electronic shared care planning
- Self-management support
- Centralised intake for community services
- Resources aligned to cluster based enhanced general practice teams
- Multidisciplinary teams
- Technology enabled case conferencing for specialist input
- Increased services provided within the community
Changing the model of care

At risk individuals:
Change required

- Care coordination
- Partners in health assessment
- Care plan
- E shared care summary
Proactive Planned Care

1. GP enrolled population
2. Risk stratification
3. Shared protocols and pathways
4. Care planning
5. Care delivery and coordination
6. Case conference

Risk stratification e-tool under development, clinical criteria agreed in the meantime.

Care pathways and agreed clinical protocols are used to inform assessment, care planning and coordination.

All ‘at risk’ patients should have a plan that is proportionate to their clinical and social needs, risks and ability to benefit: Logged on e-shared care.

Case conferences to be used from time to time for very complex patients who need MDT input to their care plan.
“It’s the little things that count, the smaller, finer points that make life easier. It’s not the big things. My care has been made up of many small things. People like Krishna have given me time. It’s important to give people time. It’s the small things.”

In memory of: Karl Farrell pictured with his Occupational Therapist Krishna Narayan and his wife Ruci Farrell
Shared Care Plan

**Personalised Care Plan**

Last modified by: (Default Designation) on 23/3/2015

**About Me**

I live with my husband, daughter and 2 young grandchildren. I also sometimes help with my 4 other grandchildren who live nearby. I work part-time.

**What Matters to Me**

My family are really important to me. I am worried that I am putting on weight and this means I can't keep up with my grandchildren.

**My Goal**

I want to be able to bend down to tie up my shoelaces so I can wear my sneakers to be able to play with my grandchildren.

**Things I Will Do:**

- I will walk to the end of the road and back at least 3 x a week.
- I will go to the self-management group that starts on Tuesday 28 April for 6 weeks.

**Things My Care Team Will Do**

- Help me understand how my diabetes affects my body
- Refer me to the diabetes Dietitian
“As we scrolled through her Shared Care Plan we came to the box where her goals and aspirations had been carefully noted. They were simple, humbling, and yet so powerful. The room fell silent. It brought the patient into the room with us. The human being was what we discussed as we kept these goals in mind.”

Gillian Aspin, Clinical Nurse Specialist - Diabetes
PARTNERS IN HEALTH SCALE V10 JUNE 2010

Name: ______________________________ ID: ______________________________
Assessment Date: / / Review Date: / /

*Person with Chronic Health Condition to Complete*

Please circle the number that most closely fits for you

1. Overall, what I know about my health condition(s) is:

   0   1   2   3   4   5   6   7   8
   Very little Something A lot

2. Overall, what I know about the treatment, including medications of my health condition(s) is:

   0   1   2   3   4   5   6   7   8
   Very little Something A lot

3. I take medications or carry out the treatments asked by my doctor/health worker:

   0   1   2   3   4   5   6   7   8
   Never Sometimes Always

4. I share in decisions made about my health condition(s) with my doctor or health worker:

   0   1   2   3   4   5   6   7   8
   Never Sometimes Always

5. I am able to deal with health professionals to get the services I need that fit with my culture, values and beliefs:

   0   1   2   3   4   5   6   7   8
   Never Sometimes Always
Partners In Health tool - A mandated task or a good investment of time?

• “I have been caring for this patient for 15 years and had no idea they knew so little about their diabetes” (GP)

• “A great starting point as we can see how much patients know about their health condition” (practice nurse)
ARI patients who have had **3 episodes** or more in the 12 months before enrolment in ARI have **reduced ED attendance rate and reduced IP episodes** following enrolment in the programme.
“Helping more than clients breathe easy”

“Feedback from General Practice is that e-shared care makes their role a lot easier, as they can see our participant’s goals and associated actions and reinforce this when they next see the patient in the practice.”

Sarah Candy, Better Breathing Programme
Positives: Patient perspective

- Appreciate the extra time
- Feel more listened to & heard
- Sharing of more in depth information - normally not time to discuss
- Enjoy having a particular nurse to relate to
- Care Coordinator is their point of contact
- Builds trust
- Grateful for the offer of support
- Spread by word of mouth (patients already enrolled make recommendations about their friends/relatives/neighbours)
Positives: Nurse perspective

- Increased knowledge of patient story/Building a good relationship
- Ability not only to identify but also offer support to vulnerable cohorts
- Time to look at people holistically
- Improved patient outcomes e.g. HBA1C, health literacy
- Coordination of care, referrals, pivotal role
- MDT meetings: sharing of information, expertise, building collegiality
- ARI has provided more focus and support from locality
- Networking with other disciplines & practices, sharing of knowledge and resources e.g. assessment tools, useful care contacts.
- Recognition of nurse input/time financially.
At Risk Individual (ARI) dashboard

Supporting patients with long term conditions to live well through more planned and proactive care and improved self management.

At Risk Current Snapshot
Key numbers & stats about our current programme:

21,328
PATIENTS BENEFITING FROM ARI PROGRAMME
Patients with long term conditions are receiving more planned, proactive care with care co-ordination and goal based care plans.

PERCENTAGE OF ENROLLED POPULATION

<table>
<thead>
<tr>
<th>Population</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Frankton</td>
<td>46</td>
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<tr>
<td>Mangere/Otara</td>
<td>14</td>
</tr>
<tr>
<td>Eastern</td>
<td>10</td>
</tr>
<tr>
<td>Manukau</td>
<td>15</td>
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ARI ETHNICITY

<table>
<thead>
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<th>Ethnicity</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Asian</td>
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</tr>
<tr>
<td>European</td>
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<td>Pacific</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
</tr>
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789
SELF MANAGEMENT REFERRALS
Patients have been supported through a formal programme to help them better manage their long term condition.

What does success look like?

21,328 → 30,000 → 50,000 → 30,000

- Patients with a shared care plan BY December 2016
- People living with long term conditions in CM will receive self-management support BY DECEMBER 2016
- Patients per year enrolled in ARI programme BY JULY 2017

- MDTs are occurring within general practice cluster networks to support care planning for complex patients.
- General practice clusters have broad networks of healthcare professionals supporting them.
- Improved self-management means patients feel more in control and understand their health condition.

For further information www.countiesmanukau.health.nz/integrated-care
Creating nursing networks

• Build phone a friend CNS/ PC clinical champions
• Changing expectations of Senior Nurse roles and responsibilities across the system
• Creating connections and opportunities
• Inclusion of Senior Nurses in PHO in DHB senior planning days
• Inclusion in education shared learning sessions
• NEtP