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

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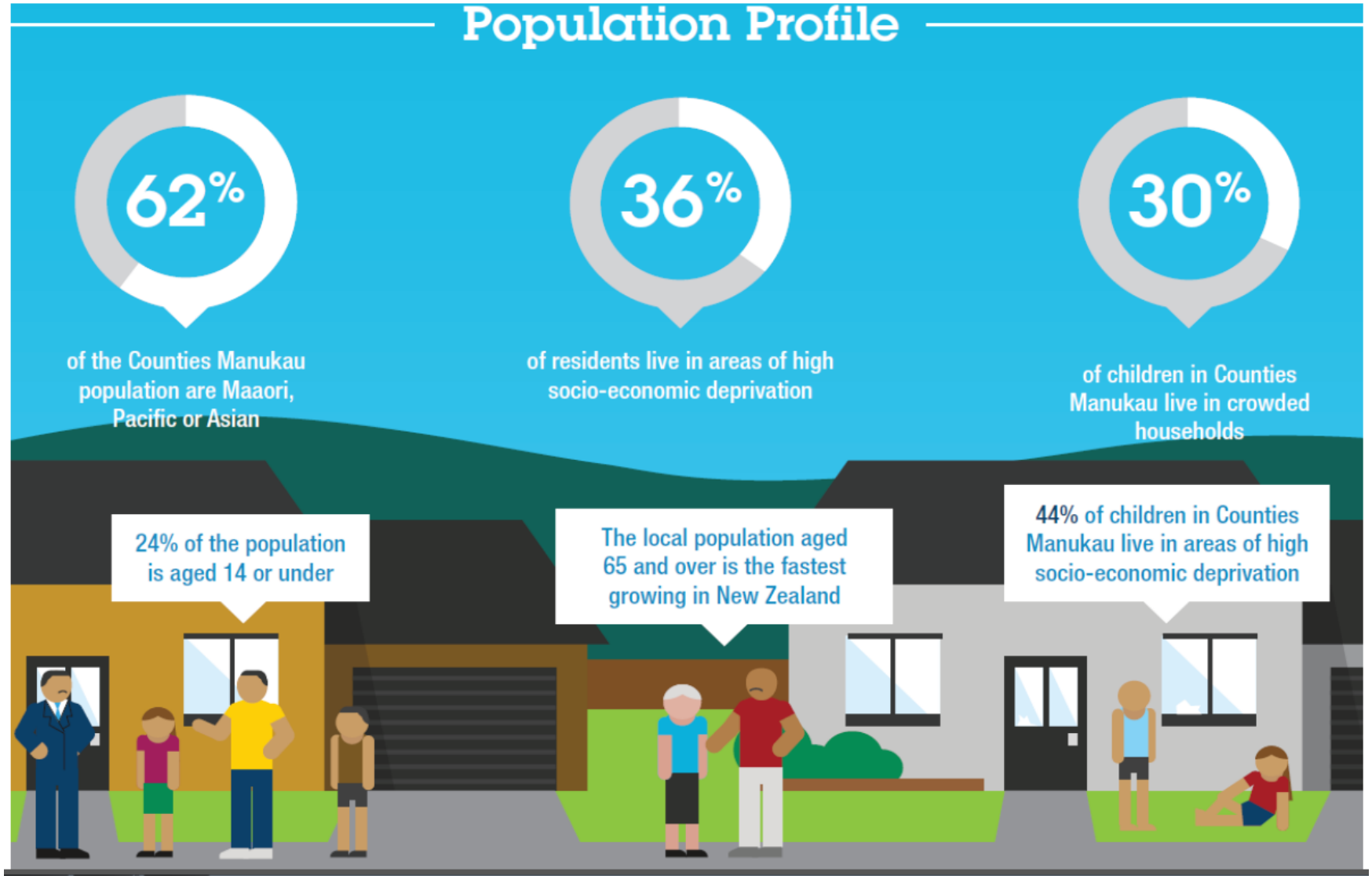
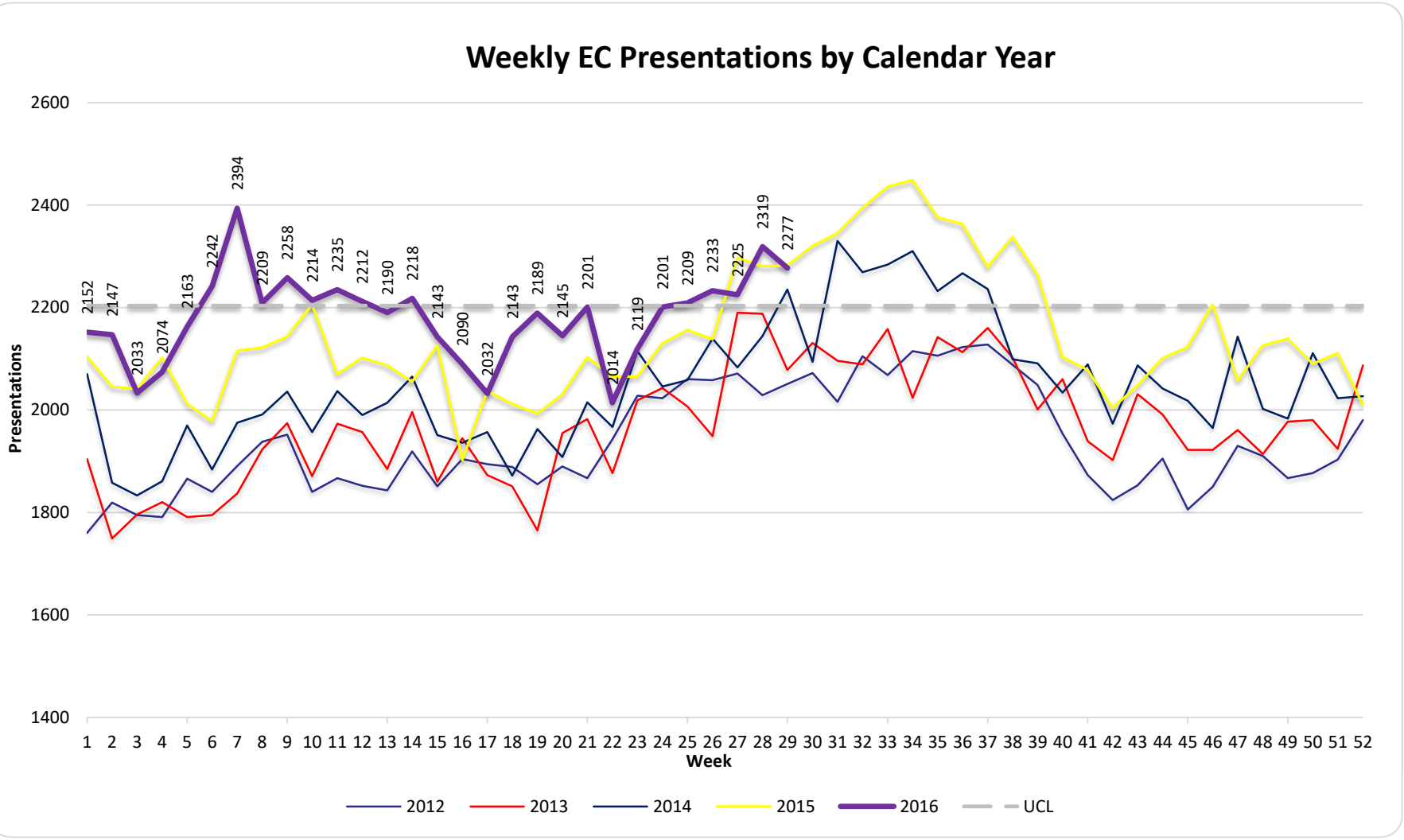
Counties Manukau Health

Counties Manukau



Need for change



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

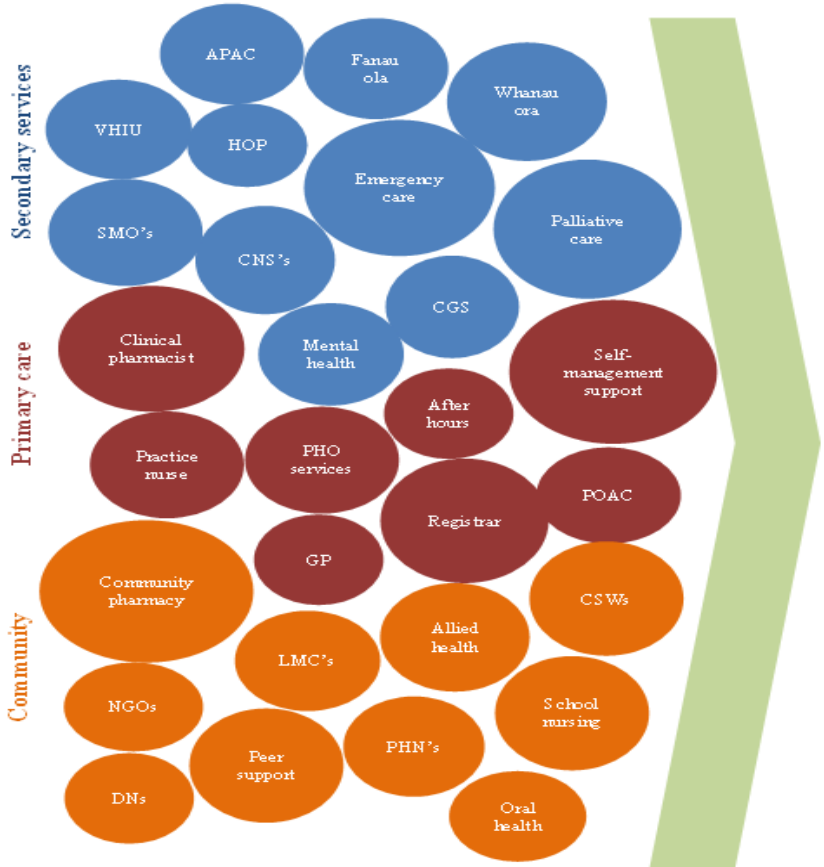
- Capacity
- Capability
- Change management
- Organisational support PHO/DHB

Guiding Principles for Transformation

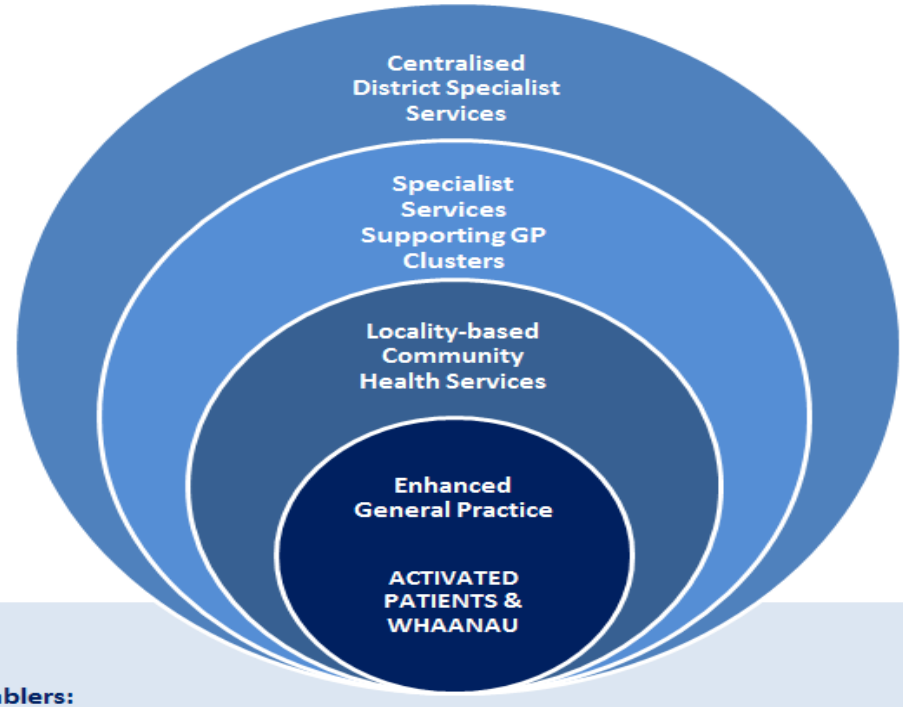
- Change needs to be led with the patient at the centre
- Strong clinical leadership
- People must connect with the benefits, reasons and vision for the change
- The culture and practice of testing, measuring and ongoing learning is critical
- Organisational change - attention and focus with changes 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.
COUNTIES MANUKAU HEALTH
Healthy Together
INTEGRATED CARE

Current State



Future State



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

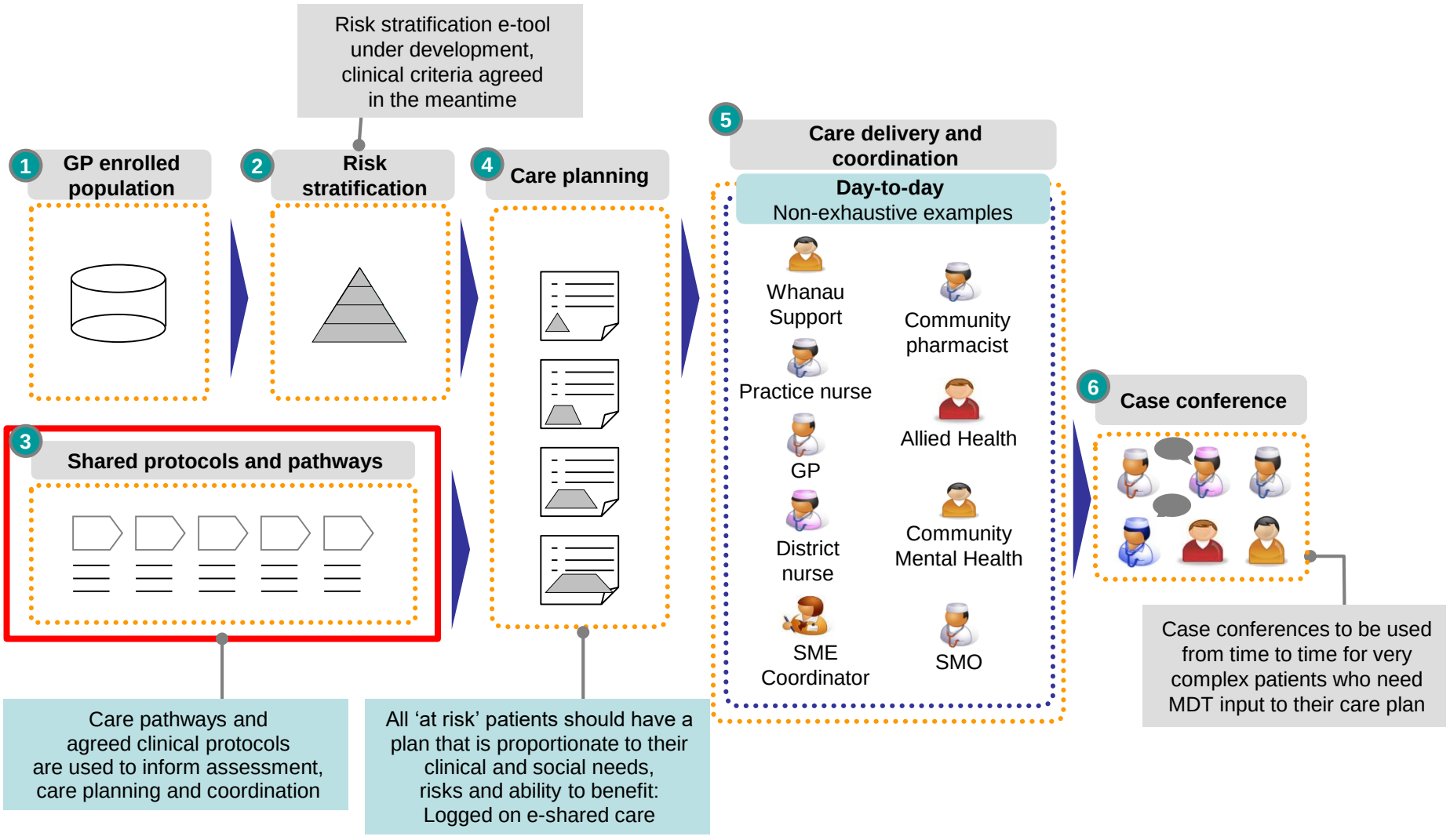
Changing the model of care

At risk individuals:

Change required

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

Proactive Planned Care



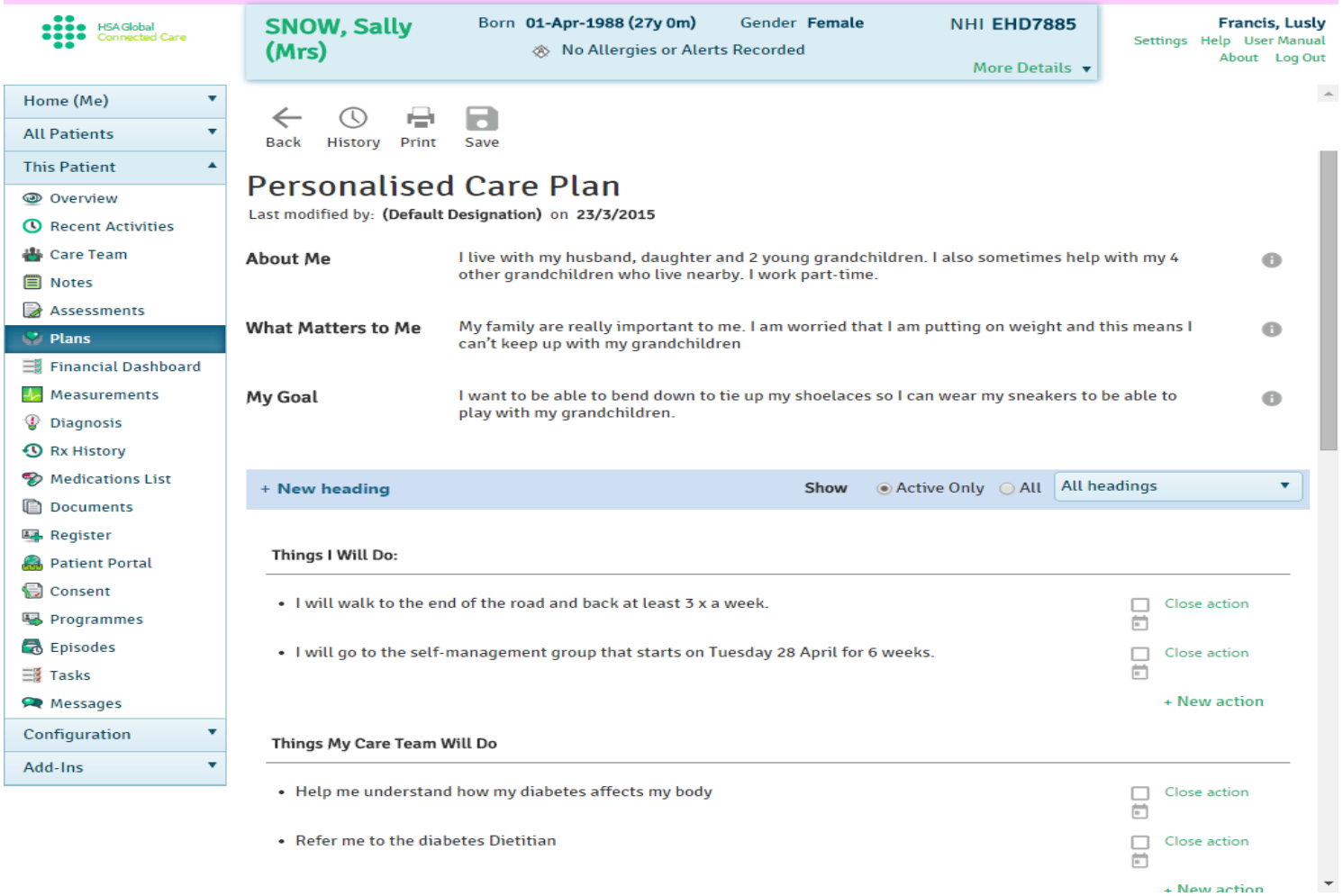
“It’s the little things that count, the smaller, finer points that make life easier. It’s not the big things. My care has been made up of many small things. People like Krishna have given me time. It’s important to give people time. It’s the small things.”

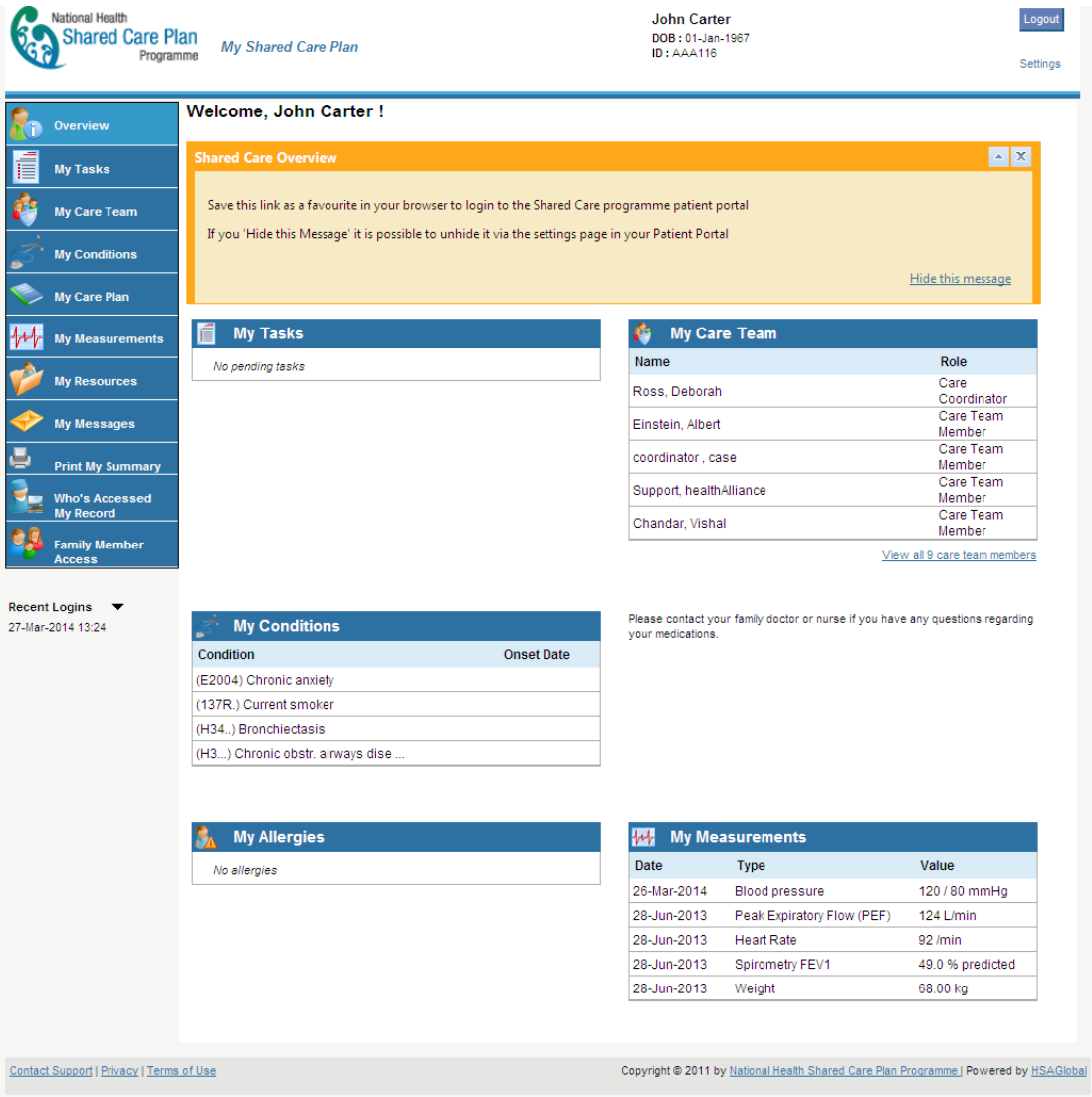
In memory of: Karl Farrell pictured with his Occupational Therapist Krishna Narayan and his wife Ruci Farrell

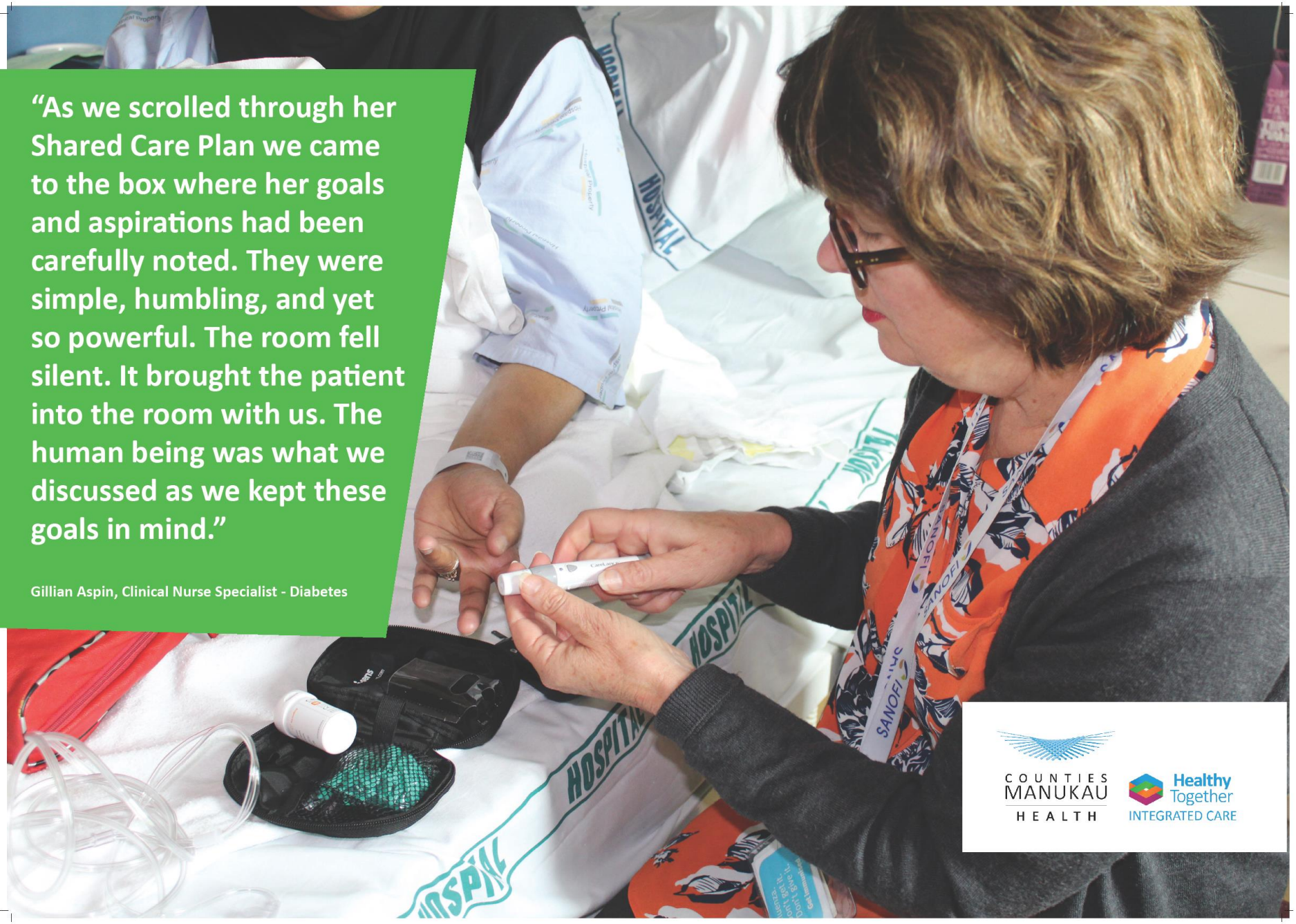
COUNTIES MANUKAU HEALTH

Healthy Together INTEGRATED CARE

Shared Care Plan




National Health
Shared Care Plan
Programme
My Shared Care Plan
John Carter
DOB : 01-Jan-1967
ID : AAA116
Logout
Settings
Overview
My Tasks
My Care Team
My Conditions
My Care Plan
My Measurements
My Resources
My Messages
Print My Summary
Who's Accessed My Record
Family Member Access
Recent Logins
27-Mar-2014 13:24
Welcome, John Carter !
Shared Care Overview
Save this link as a favourite in your browser to login to the Shared Care programme patient portal
If you 'Hide this Message' it is possible to unhide it via the settings page in your Patient Portal
Hide this message
My Tasks
No pending tasks
My Care Team
Name
Role
Ross, Deborah
Care Coordinator
Einstein, Albert
Care Team Member
coordinator , case
Care Team Member
Support, healthAlliance
Care Team Member
Chandar, Vishal
Care Team Member
View all 9 care team members
My Conditions
Condition
Onset Date
(E2004) Chronic anxiety
(137R.) Current smoker
(H34..) Bronchiectasis
(H3...) Chronic obstr. airways dise ...
Please contact your family doctor or nurse if you have any questions regarding your medications.
My Allergies
No allergies
My Measurements
Date
Type
Value
26-Mar-2014
Blood pressure
120 / 80 mmHg
28-Jun-2013
Peak Expiratory Flow (PEF)
124 L/min
28-Jun-2013
Heart Rate
92 /min
28-Jun-2013
Spirometry FEV1
49.0 % predicted
28-Jun-2013
Weight
68.00 kg
Contact Support | Privacy | Terms of Use
Copyright © 2011 by National Health Shared Care Plan Programme | Powered by HSAGlobal



"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

COUNTIES MANUKAU HEALTH

Healthy Together INTEGRATED CARE

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:

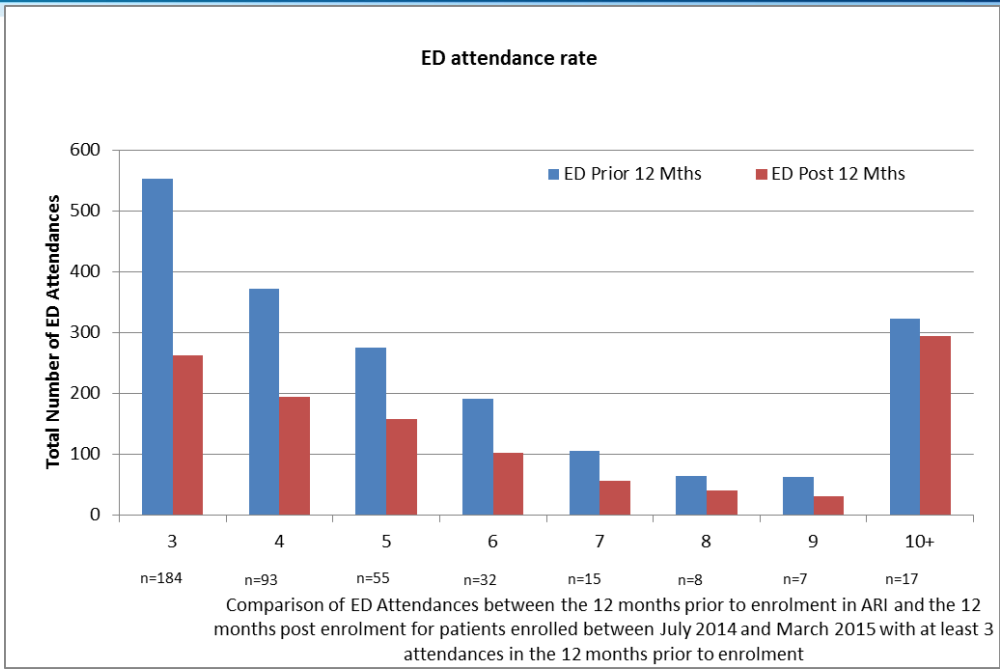
0 1 2 3 4 5 6 7 8

Never **Sometimes** **Always**

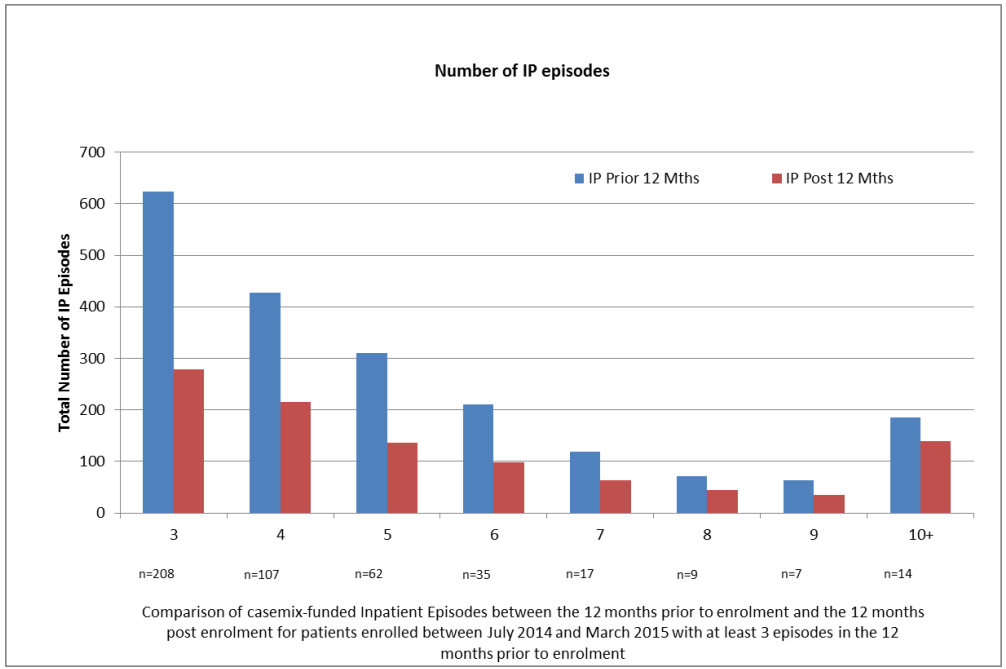
Partners In Health tool - A mandated task or a good investment of time?

- *"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.



Comparison of ED Attendances between the 12 months prior to enrolment in ARI and the 12 months post enrolment for patients enrolled between July 2014 and March 2015 with at least 3 attendances in the 12 months prior to enrolment



Comparison of casemix-funded Inpatient Episodes between the 12 months prior to enrolment and the 12 months post enrolment for patients enrolled between July 2014 and March 2015 with at least 3 episodes in the 12 months prior to enrolment

“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.

As at 31 July 2016

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.

MORE THAN

60,000

PATIENTS WITH A LONG TERM CONDITION IN COUNTIES MANUKAU

21,826

SHARED CARE PLANS

Patients with a goal based care plan that is electronically shared with the care team members.

PERCENTAGE OF ENROLLED POPULATION

ARI ETHNICITY

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**	Patients with a shared care plan **BY December 2016**
21,328	**50,000**	People living with long term conditions in CM will receive self-management support **BY DECEMBER 2016**
1,328	**30,000**	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**

COUNTIES MANUKAU HEALTH

Healthy Together 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