To “in-reach” or “out-reach”
that is the question

Chiquita Hansen
Director of Nursing Primary Health Care - MidCentral District Health Board
Chief Executive Officer - Central Primary Health Organisation
Microsystem Festival – Jonkoping
26th February 2015

We have successfully proven our hypothesis
"With General Practice current focus on managing the acute episode of chronic disease (due to workload, limitation of facility) can we organise ourselves to develop a structured integrated interdisciplinary care environment that is "needs led" to improve health outcomes".

Specialist resource based in community settings aligned to general practice teams with effective linkages (in-reach) to specialist services targeted at the "right population", practicing to the "top of their licence", co-designing patient pathways, supported by practice based learning and post graduate study has improved health outcomes.

We have successfully negotiated the challenge of service integration between hospital and community based care in our district.
“To Be” or “Not to Be” – “To In-Reach” or “Not to In-Reach”
That is the Question

What is it I am referring to when I say “to in-reach or out-reach”? “Specialist expertise”

“To Do Is To Be” - Nietzsche
“To Be is To Do” - Kant
“Do Be Do Be Do” - Scooby Doo

To “in-reach” specialist expertise - should be Client/Primary/Community driven
To “out-reach” specialist expertise is specialist/hospital driven – is often a drag and drop model
Our History

- 2003 Health Needs Assessment
- Primary Health Care Strategy 2004 – followed by investment in PHC. Goals:
  - Access
  - Community participation
  - Coordination of services
  - PHC infrastructure development
  - Integration between primary & secondary care
  - Quality

Our Focus

What is the most important thing in the world? It is people! It is people! It is people!

2004-2010 we invested in:

**PEOPLE & PROGRAMMES**
- Diverse range of additional positions (70) in PHC (chronic care teams) mostly through PHOs
- Palliative Care Partnership
- PHC Mental Health
- PHC Sexual Health
- Community Paediatric team
- Community Radiology

**SYSTEM & STRUCTURES**
- Establishment of PHOs
- Nursing Development Team (now known as Health Care Development)
- Diagnostic technology
- Decision support software
- Knowledge and Skills frameworks
- Chronic Care Model
- Levels of Care Framework
- Research
We have based our investment on Professor Barbara Starfield (1932-2011), who championed the value and need of strong primary health care systems worldwide.

The 'Case for Primary Health Care'
There is now good evidence, from a variety of studies at national, state, regional, local, and individual levels that good primary health care is associated with better health outcomes (on average), lower costs (robustly and consistently), greater equity in health, and less waste (inappropriate use of specialists). Starfield 2010.

We have based our investment on Ed Wagner Chronic Care Model
We have stratified the population.

We have focused on service delivery model.
Our approach

<table>
<thead>
<tr>
<th>Microsystem 5 P’s</th>
<th>NZ Treaty 3 P’s + 2 more</th>
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</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Partnerships</td>
</tr>
<tr>
<td>Patients</td>
<td>Participation</td>
</tr>
<tr>
<td>Professionals</td>
<td>Protection</td>
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<tr>
<td>Processes</td>
<td>Passion</td>
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<tr>
<td>Patterns</td>
<td>People Centered</td>
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</table>

**Partnership:** interactions between partners must be based on mutual good faith, cooperation, tolerance, honesty and respect

**Participation:** secures active and equitable participation

**Protection:** we must protect whakapapa, cultural practices and taonga

Better Sooner More Convenient Ministry Policy 2010

- Develop a more personalised primary health care system
- Provide services closer to home
- Make New Zealanders healthier
- Reduce pressure on hospitals
**Alliance Framework/Principles**

- Relationship focus based on alliance principles – **high trust, good faith, consensus**
- Clinical, Maori/Iwi, Management leadership of service development
- Integration - ‘**single system’** approach focused on patients
- Open and transparent **information sharing**
- Joint decision-making
- High accountability for **agreed outcomes** and common performance targets
- **Low** level of bureaucracy
- Ability to evolve

**Aspirational Targets**

- Clinical leadership will actively drive service development across the sector
- Reduce presentations to ED by 30%
- Reduce ASH admission for over 65s by 20%
- Reduce the rate of growth in total aged residential care expenditure to 5% per year
- Reduce the rate of GP-referred pharmaceutical expenditure to 1% per year
- Increase Maori enrolment in a PHO to 100%
Aspirational Targets

- 100% of enrolled patients will have access to their own health records by 2013
- 100% of health professionals will have access to up to date patient health records
- Health care providers will work within a common assessment and care planning framework
- 80% of people aged over 65 with moderate complexity health needs will receive co-ordinated structure care through General Practice teams

Programmes of Activity in the Midcentral BSMC Business Case

**Health Assessments**
- Annual CHA & Plan of Care
- CHA & InterRAI assessment
- WHĀNAU ORA Assessment & Plan of Care

**Chronic Care Management**
- Chronic Care Model in GPT
- Enhanced Care
- Case Management
- Self-management programs
- Clinical Pharmacy service
- Population stratification
- Case management for older persons
- Centralised referrals
- DIE/PHO
- WHĀNAU ORA self-management support groups

**Acute Care Management**
- Healthline
- Urgent Community Care
- District Nursing Hospital Avoidance Programme
- Nurse led Walk in clinics
- WHĀNAU ORA Navigators

**Clinical Networks & Pathways**
- Clinical Networks and Collaborative Clinical Pathways
- Primary Care Management of Community Referred Radiology Service
- System Levers
  - Clinical Leadership & Innovation Pipeline
  - Clinical Governance
  - Workforce Development
  - Information Management

**IHCS**
- Systematic
- Clinical
- Functional
- Service
- Organisational
- Normative

**Integration**
Governance

- Central PHO Charitable Trust and Alliance Leadership team formed as a clinician-led governance body
- Focus is on delivering core PHO functions, enhance primary health care development and driving integration, improved patient pathways, service improvement, change programmes and whole of system thinking
- Central PHO/ALT is supported by an Alliance Management Team
- Chair and CEO hold DHB leadership positions
Given lower GP numbers in MidCentral – what is supporting our reduced ED and hospitalisation stats?

- Development of Integrated Family Health Centres
- PHO Clinical Long Term Condition staff are aligned with Practices and focused on higher risk patients
- Practice profiling, risk stratification and service response matrix becoming the norm
- Improved System Participation:
  - Staff engagement
  - Transformational Leadership programme
  - Collaborative Clinical Pathways
  - Clinical Networks
  - International Masterclasses
- Rings of Care
- Role of specialists within rings of care
Investment in improving long term condition management across MDHB district

PEOPLE
Diverse range of additional (70+) PHC positions:
nurses, dieticians, physiotherapists, social workers, smoking cessation, physical activity educators,
clinical pharmacists, community support workers, podiatrists, cardiologists and cardiac technicians.
The general practice team is the home of the patient.

PROGRAMMES

Practice profile and service response matrix
Tararua Health Group – 14,275 Enrolled Population

Patient Segmentation

<table>
<thead>
<tr>
<th>Health Need Group</th>
<th>Population Health</th>
<th>Long Term Condition Management</th>
<th>Acute Care</th>
<th>High Cost Services</th>
<th>Special Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HG1: Well</td>
<td>Lifestyle Smoking, Nutrition, Exercise, Alcohol</td>
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<tr>
<td>HG2: At Risk</td>
<td>Risk assessment</td>
<td></td>
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<tr>
<td>HG3: Early</td>
<td>Targeted interventions: As above plus hypertension</td>
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<tr>
<td>HG4: Advanced</td>
<td>Care plans, Home based care, Mental health/ Psych support</td>
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<tr>
<td>HG5: Complex</td>
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Acute clinic
After hours etc.
POAC

ED, Support PHC

Structured care, eg: RESPRATORY, IRC

Care Plan (planned response)
Home management
Case management

MidCentral DHB | 2014 | The route to improved outcomes
Central PHO Staff engagement survey results
February 2015

Transformational Leadership Programme
(For Us By Us)

- 12 programmes over 4 years
- 260 participants across sector/levels/professions
- 3 two-day modules (You/Teams/Improvement)
- Adaptive challenge
- 4 coaching sessions
- Participant satisfaction high
Collaborative Clinical Pathways

"Here is a referral from Dr X which I think should have been dealt with in primary care. I have now arranged for the poor patient with suspected DVT to be scanned at Broadway this afternoon. Dr X is a repeat offender with this. I have tried to phone and speak to her but they are closed for lunch (!!!!) nice life

Please can you pass on the message?

The community pathway is soooooooooooooooooo much better for the patient than coming to ED it should be a no-brainer"

ED Director and Consultant
MidCentral Health
Palmerston North
Clinical networks

- Clinical Networks:
  - Child Health Tamariki Ora
  - Health of Older People
  - Mental Health and Addictions
  - Urgent and Acute Care
  - Long Term Conditions
  - Cancer
  - Palliative Care.

Each network has a work programme that connects our local and regional service developments, quality improvements, development and delivery of priority initiatives including Collaborative Clinical Pathways.

200 people contribute to the clinical networks.

Each network has a clinical lead, supported by portfolio manager and project management support.

12 people on each network – primary, secondary, Māori, community and intersectoral.

Number of working groups.

Dr Bruce Stewart Medical Director PHC DHB provides overall leadership.

Examples of some projects led by the Clinical Networks:
- Investigating and developing primary options for acute care,
- Establishing a centralised after-hours service in the Horowhenua,
- Increasing the level of health literacy of Highbury community members,
- Supporting the use of dermatoscopes within general practice as part of the collaborative clinical pathway.

International MasterClasses

MidCentral DHB and Central PHO are undertaking a large-scale transformational change journey towards excellence in health outcomes, with a focus on integrated care and partnering.

For the vision to be realised, there must be distributed clinical and administrative leadership throughout the health care sector. This leadership must not only have a clear perspective on the local vision, but must be exposed to the best current thinking on health care systems development internationally. It is important we have a strong group of leaders who are able to see beyond the thinking which binds our current systems to the status quo. Providing a mixed group of primary and secondary care colleagues with the opportunity to participate in a Masterclass experience breaks down barriers and develops relationships which will support the integration agenda.
Rings of Care

Hospital Care

Intersectoral Agencies
- Justice
- Police
- Housing
- Welfare
- NGOs

Specialist Services

Primary and Community General Practice Teams

Rings of Care

Provide direct, high complexity clinical care

Develop capability through case review, peer review, collaborative consults and clinical advice

Grow population health in partnership with General Practice Teams

Support codesign agenda - pathways, patient engagement & clinical networks

Co-drive system leadership, quality improvement & clinical governance

The Role of Specialists within Rings of Care

Specialists supporting IFHC/General Practice health homes in providing the most appropriate care
Specialists Integrated Care Examples

<table>
<thead>
<tr>
<th>General Description</th>
<th>Kidney Health in the Horowhenua (KHH)</th>
<th>Palliative Care Partnership</th>
<th>Health of Older People</th>
<th>Community Cardiology Service</th>
<th>Specialist Diabetes Nursing Service</th>
<th>Community Child Health Team</th>
</tr>
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<tbody>
<tr>
<td>Nurse-led general practice based care for people at risk of renal disease</td>
<td>Community-led, community-based palliative care programme based on a partnership between GPs, specialist palliative care and Central PHO with key linkages to district nurses</td>
<td>Community-based MDT co-ordinating care for older people</td>
<td>Consultant-led, community-based home care for people with cardiac disease</td>
<td>Nurse-led general practice based care for people with diabetes</td>
<td>Nurse-led, paediatrician supported, general practice based team care for children with asthma and eczema</td>
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Our Palliative Care Partnership is in sync with High Performing Health Care Systems

Dr Eileen McKinley 2006: Mid Central Health, Evaluation of the Palliative Care Partnership, Wellington School of Medicine 2006

The Palliative Care partnership was established in Mid Central in 2004 to ‘provide enhanced palliative care services through quality coordinated health care using both specialist services and generalist services’.

10 characteristics of the successful integrated model of care:

- Shared governance and management structure
- Equal input from generalist and specialists
- Specific funding stream
- An integrated care pathway
- Planned change management processes
- Early entry into service
- Culturally appropriate care
- Involvement with community organisations
- Support to residential care settings
- In-built quality assurance processes

Dr Ross Baker 2011: The roles of leaders in high-performing health care systems Kings Fund.

Identifying improvements to current care delivery structures and translating approaches from high-performing systems to local delivery organisations will help to spread more reliable and cost-effective care.

Key themes underlying high-performing health care systems

- Consistent leadership that embraces common goals and aligns activities throughout the organisation.
- Quality and system improvement as a core strategy.
- Organisational capacities and skills to support performance improvement.
- Robust primary care teams at the centre of the delivery system.
- Engaging patients in their care and in the design of care.
- Promoting professional cultures that support teamwork, continuous improvement and patient engagement.
- More effective integration of care that promotes seamless care transitions.
- Information as a platform for guiding improvement.
- Effective learning strategies and methods to test improvements and scale up.
- Providing an enabling environment buffering short-term factors that undermine success.

Kiwi intuition

2004

Research 2011
Diabetes Outcomes

Six General Practices part of study
Number of patient admissions reduced by 55%
average LOS reduced by 53%
MDT outpatient specialist input reduced by 27%

“I like the way she won’t just take on everyone she will let you deal with it, she has confidence in your skills and she will guide you” GP

One practice nurse said “it was meant to be not only about improving patient care but about improving our knowledge so that we could pass it on. That’s how I interpreted it and I certainly feel that has happened”.

Important enabler was communication, both face-to-face and electronic. The tea room was mentioned as being an important hub of the practice where discussions and updates take place. The ‘chat over a cup of tea’ was described as “important but not measured”; the informal level of chat in confidence enables a lot to be achieved. GP
Specific example contributing to outcomes
Nurse Practitioner: Older People

- The rate of ED visits decreased by 28% post NP intervention compared to a 21% increased rate for facilities without a NP over a one year period.
- Acute hospital admissions were decreased by 22% post NP intervention compared to a 21% increased rate for facilities without a NP.
- Hospital admissions with diagnoses that could possibly have been avoided through earlier intervention were decreased by 26% post NP intervention compared to an 18% increase in facilities without NP.

Conclusion

He tawhitii 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......

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