

PRIMARY HEALTH CARE NURSING INTEGRATION: BRIDGING THE GAP WITH CO-DESIGNED SHARED CARE

Lesley Batten¹, Mandy Bevan (Presenter)², Debbie Davies², Paul Cooper¹

¹ Central Primary Health Organisation, Palmerston North, New Zealand
² MidCentral District Health Board, Palmerston North, New Zealand

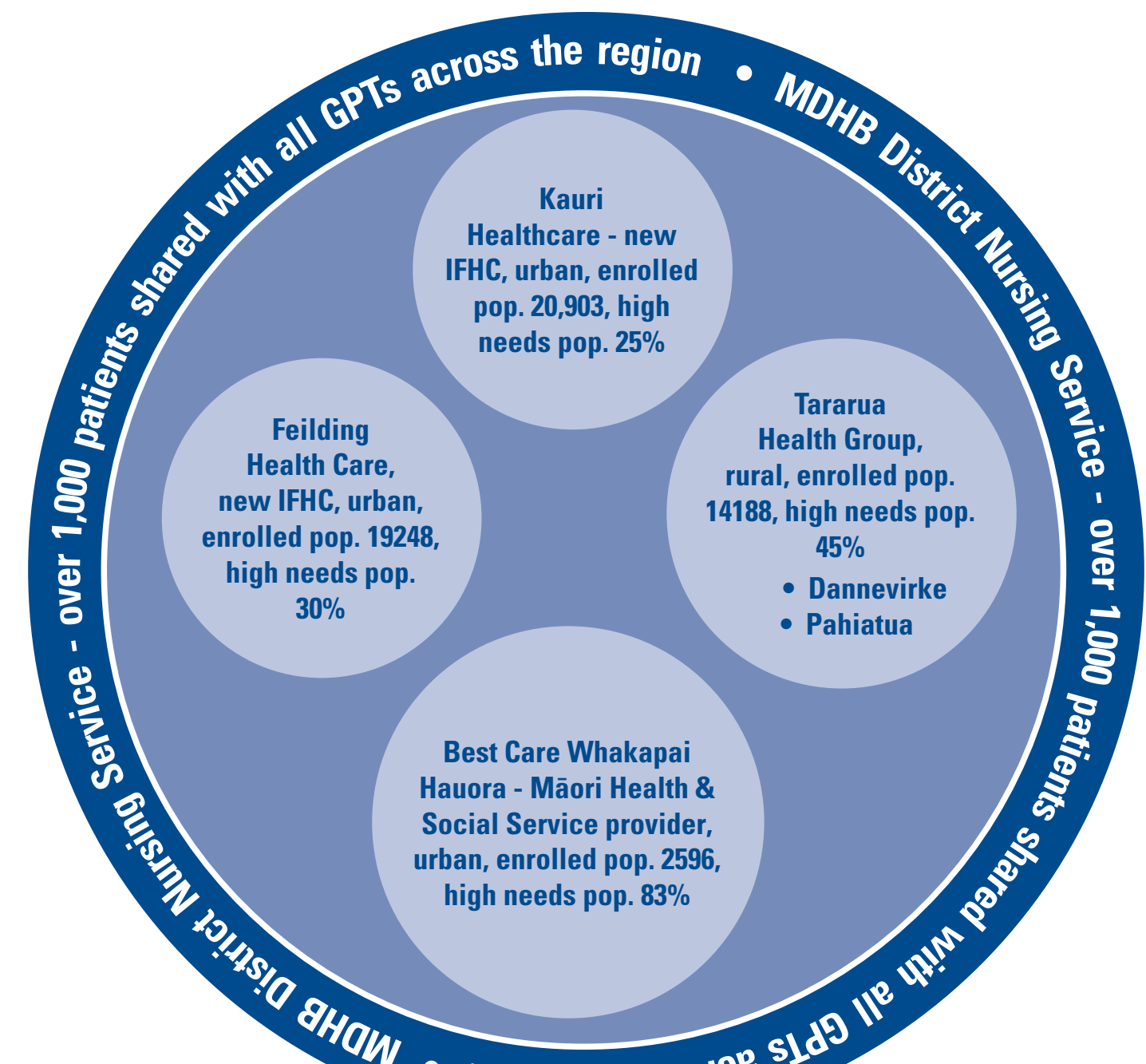
INTRODUCTION

The Primary Health Care Nursing Integration project is a collaboration between the Central Primary Health Organisation (CPHO), the MidCentral District Health Board (MDHB) and primary health care services, all based in the lower North Island of New Zealand. The MDHB region covers a population of over 170,000, stretching from the West to East coasts. This population has a higher than average proportion of priority populations.

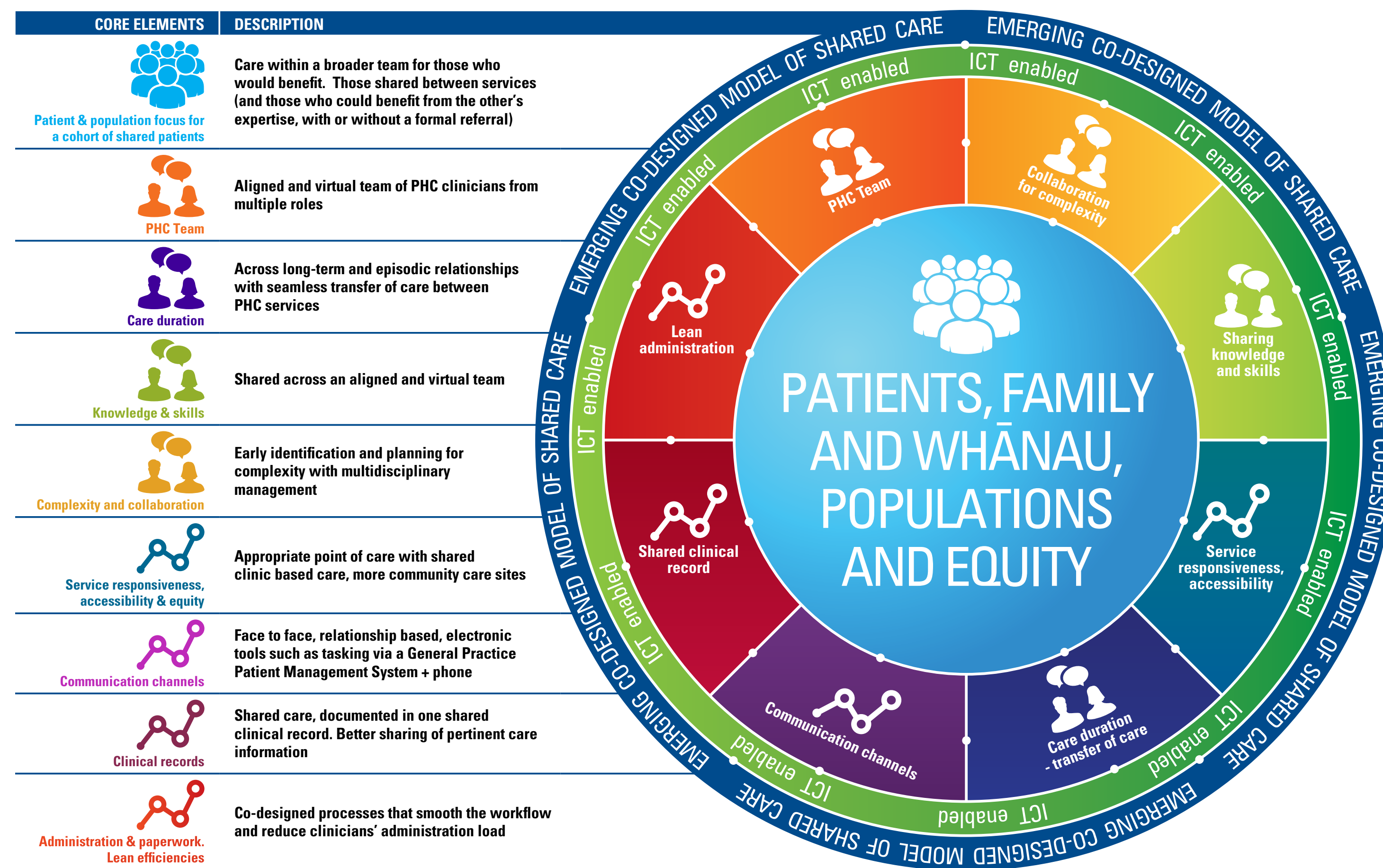
While the initial project focus related to the lack of alignment of the many Primary Health Care (PHC) nursing roles, the primary system dysfunction was the lack of integration between and across PHC and secondary services, resulting in disjointed patient care. Aims include best use of the total PHC nursing workforce, irrespective of employer, and nurses working to the top of their scope. The use of coproduction methodologies has broadened the project to encompass implementation of a co-designed model of shared care to bridge the gaps between services. This significant directional shift results in the scope extending past 'roles' and 'personnel' to care approaches and streamlined systems.

PROJECT APPROACH

- Via an expression of interest process, all General Practice Teams (GPTs) in the region were invited to become co-design partners with the MDHB District Nursing Service (DNS). Four GPTs (5 sites), with a representation of rural, urban, new Integrated Family Health Centres (IFHC), small and large practices, and Māori Health Providers are involved.



CO-DESIGNED MODEL OF SHARED CARE FOR PRIMARY HEALTH CARE NURSING INTEGRATION



- Change Processes and Priorities**
 - Relationships – face to face meetings, patient care discussion opportunities
 - Understanding other services (& how they work, what they do, what they need)
 - Streamlining processes & workflows
 - Using other tools, such as clinical pathways
 - Linking with other projects for consistent messaging, reducing service burden
 - Testing, evaluating, testing, evaluating
 - ICT – sub-project
 - Different degrees of alignment depending on service configurations.
- Consumer engagement took place through in-depth interviews. With consent, patient journeys were mapped. These maps were utilised to initiate discussion at co-design workshops.
- Patient Journey Map**

Female, 70s, independent, lives alone. District Nursing involvement 4-6 times over the past 18 months for a Post surgical wound dressing; 3. Lower leg eczema, 1st another chronic condition, well managed.

WHAT WOULD MAKE A DIFFERENCE? If I could just go down to the clinic & ask the nurses to look at them. And if the doctor could listen – but because I haven't got a GP they just get things. I would certainly like to know the doctor I am going to, that I can go to every time. I have got another condition & nobody there knows about it. I'm not sure my results. Everyone tells me something different. A shared plan would be useful.

• Does as much as she can to manage her condition – uses creams, wears stockings, elevates legs when possible
 • Doesn't have a written ongoing plan
 • Do the GPs know what the DNS are doing? – No. Do the DNS know what the GPs are doing? – No
 • I don't have the same doctor. I have seen about 5 or 6 doctors & I just get to see whoever is around. No one has said 'what are you on at these tablets for?' They all have different ideas about what to do. There are all these different doctor's names on the letters & prescriptions & I don't know who the person giving the prescriptions is. There is no continuity of care. I don't know who the GPs are.

KEY PATIENT MILESTONES	PHASES	Home	GPT	District Nursing clinic	Hospital ward surgery	GPT referral	District Nurses (home visits)	Home	GPT	District Nurses (clinic)	Home
Time											

← OVER APPROXIMATELY 18 MONTHS →

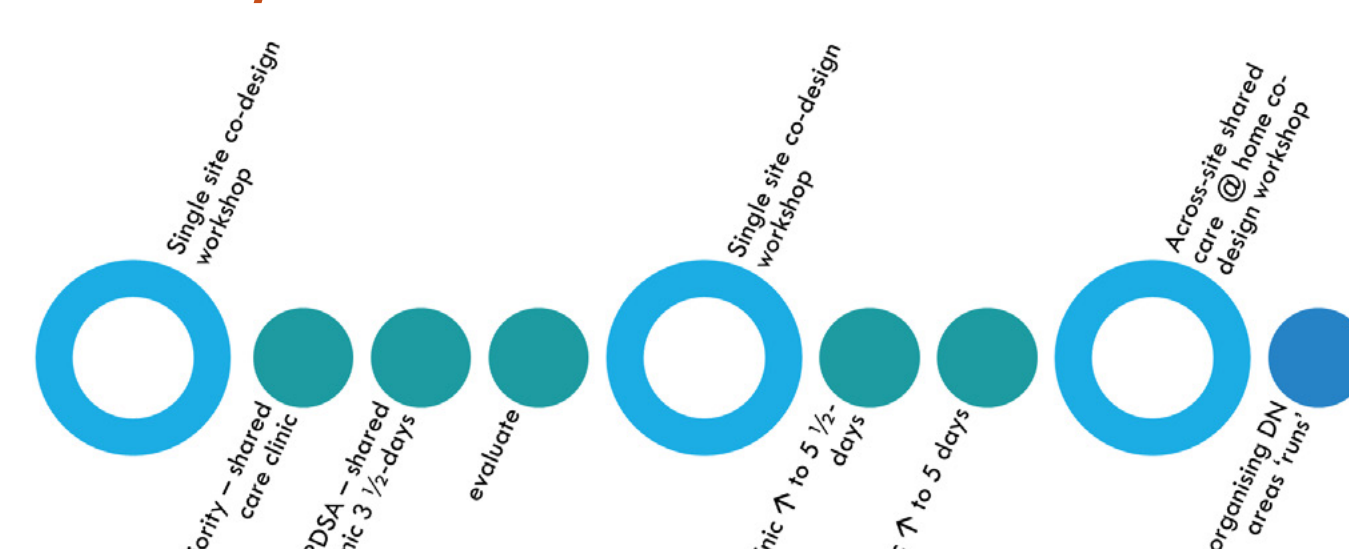
- Key findings Phase 1**
- Patient focused care but:
 - Busyness & heavy task workloads
 - Silo-ed services – gaps, uneven patient transitions, unintended consequences
 - Poor information transition
 - Poor knowledge of other services, coordination across services
 - Absence of ICT for District Nurses
 - Complex needs, complex care
 - Multiple projects underway
 - Co-location ≠ integration

PHASE TWO

Local priorities were developed from each phase one workshop and testable solutions for Plan-Do-Study-Act (PDSA) cycles agreed. One PDSA example was to test the development of a 'shared care clinic' run by District Nurses within a new IFHC. Objectives were to:

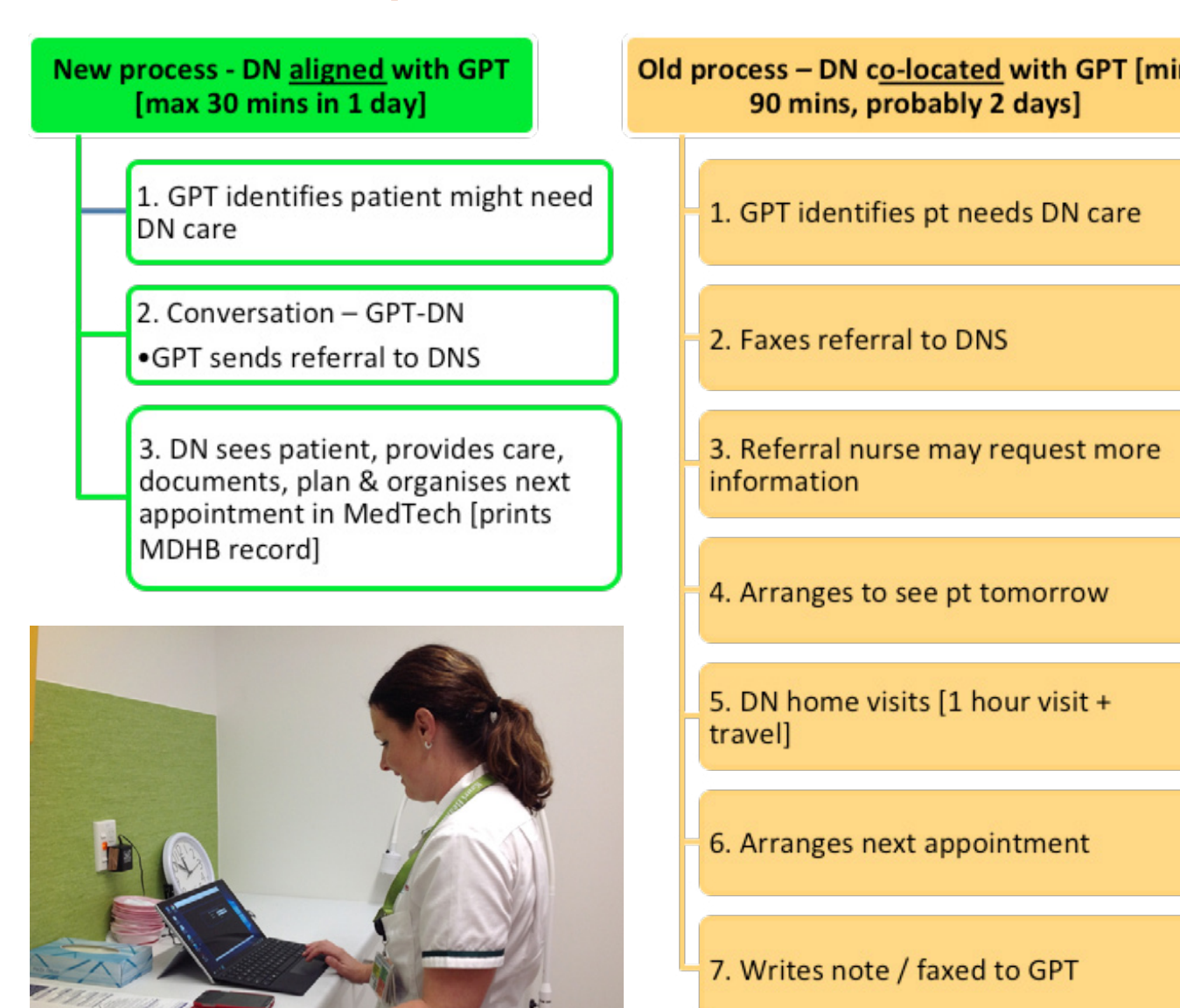
- Improve visibility of District Nurses as new members of the IFHC team
- Offer shared patients the option of receiving District Nursing care at their 'health home' (IFHC)
- Test processes of District Nurses documenting in-clinic care in the IFHC clinical records
- Improve shared understanding of patient care roles
- Improve understandings of shared patient care, especially for those with long term or complex care needs.

Case Study – test shared care clinic



- The clinic started three part days per week and has now increased to five days per week, with very positive outcomes for patients and staff (both the GPT and District Nursing).

Shared care clinic process changes



Shared care clinic outcomes – trust, team, teamwork

- Patient choice – opportunity costs
- Time released to care
- Earlier interventions
- Appropriate, timely referrals to other services
- Patients know team (& know the wider team knows!)
- Reduced requests for patient details
- Plan of care – in notes, identical plan given to patient
- Staff satisfaction
- Seamless transfers...

CO-DESIGNED MODEL OF SHARED CARE

- This co-designed model was a key outcome of Phases One and Two, and provides the basis for Phase Three.
- TOOLKIT COMPONENTS**, necessary for the Shared Care Model to work effectively, have been tested in PDSA cycles on individual sites. However, due to delays in ICT implementation across the health sector, not all components have been tested on all sites
- All **ICT ENABLED** components have been tested in a limited way. MDHB progress on their Digital Strategy will ensure all can be tested in the future

TOOLKIT COMPONENTS	ICT ENABLED
Identifying patients shared between services	Using the General Practice Team Patient Management system (GPT PMS) for shared clinical records
Identifying clinicians involved in each patient's care. Flexible care coordination	District Nursing Service (DNS) template for clinical records in the GPT PMS
Flexible coordination of care, especially for patients with complex needs	Remote District Nurse (DN) access to the GPT PMS
Shared care clinics for early referral, information sharing, seamless care transfer	Communicating electronically for non-urgent matters
Nurse-to-nurse regular meetings, including attending General Practice Team (GPT) huddles	Identifying other clinicians / roles involved in clinical records
PHC team involvement in MDT discussions, incl. specialist meetings such as Health of Older Person team	A single patient focused plan of care (including for self management)
Increased use of clinics for those able to attend	Transfer of care to the GPT on DNS discharge
Home-based care when appropriate	Accessing the GPT patient summary via the MDHB portal
Streamlined transfer of care processes to provide advice at referral, earlier care at referral when appropriate	A lower limb wound prevention and management health pathway
Increasing supported self management	Supported self-management plan discharge summaries for patients
Skills and knowledge shared for better patient outcomes, focusing on the right person with the right skills and knowledge providing care in the right place at the right time	Virtual consults
Better understandings of patient complexity factors (research underway)	Clinical photos
Early transfers of care in all directions	Standardised referral templates for GPTs
Local communication routines for the PHC team	Automatic acknowledgement of referrals received by the DNS
Reduced care documentation processes for District Nurses	GPT alerts to DNS for events with shared patients, such as hospitalisations or deaths
Link roles for smaller practices	
Increased service level relationships	

Over phases one and two many lessons have been learned, which are being considered in Phase Three.

Lessons Learned

- Co-design takes time (& expertise)
- Link with like projects
- Use data (& evidence) for change & evaluation
- Blue sky thinking is hard
- ICT is an enabler, not the project
- There is much goodwill, but resourcing is important
- One bite at a time
- Working across services, including public and private, comes with its own challenges.

PHASE THREE UNDERWAY

- Plan for Phase Three**
 - Increasing the number of General Practice sites, equity focus
 - Implementing shared care @ home
 - Reorganising the District Nursing workforce for complexity
 - Scaling to the wider PHC nursing workforce
 - Testing other degrees of alignment across the range of numbers of shared patients between services.

CONCLUSION

This project is work-in-progress. It demonstrates the positive impacts of following co-design principles to address widely experienced health sector integration challenges. The model of shared care that emerged from the first project phases, and which is being used to structure the third phase, has shifted the initial focus from roles and employers to care approaches and streamlined processes. ICT integration across organisations remains a key barrier to progress. However, effective service-level relationships have been developed, and patient and family focused solutions are informing all future developments.

PHASE ONE

- The overall focus was improving patient care - bridging the gaps in patients' journeys – and equity of service access and outcomes. No preset model was chosen. However, based on a literature review, we adopted a theoretical perspective that integration occurs along a continuum from segregation to full integration. There is no single degree of integration that is optimum for all services or care programmes.

Phase One Methodology

- Methodology - scoping & co-design
 - Interviews
 - Data & document analysis
 - Focus groups
 - Mapping patient journeys
 - Observations
 - Considering national & international lessons

Corresponding Author **Lesley Batten**
 Lesley.Batten@midcentraldhb.govt.nz

