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

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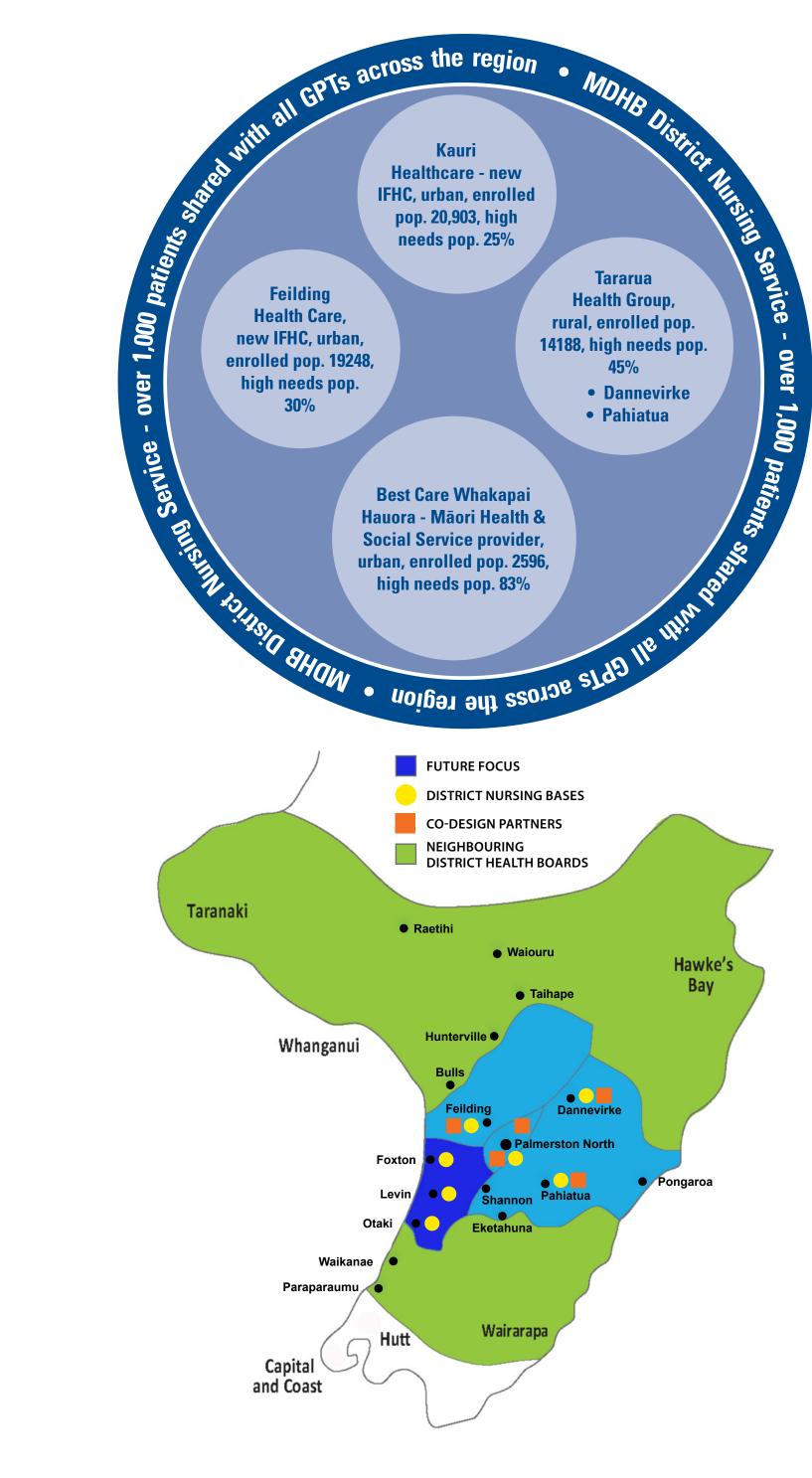
CO-DESIGNED MODEL OF SHARED CARE FOR PRIMARY HEALTH CARE NURSING INTEGRATION CO-DESIGNED MODEL

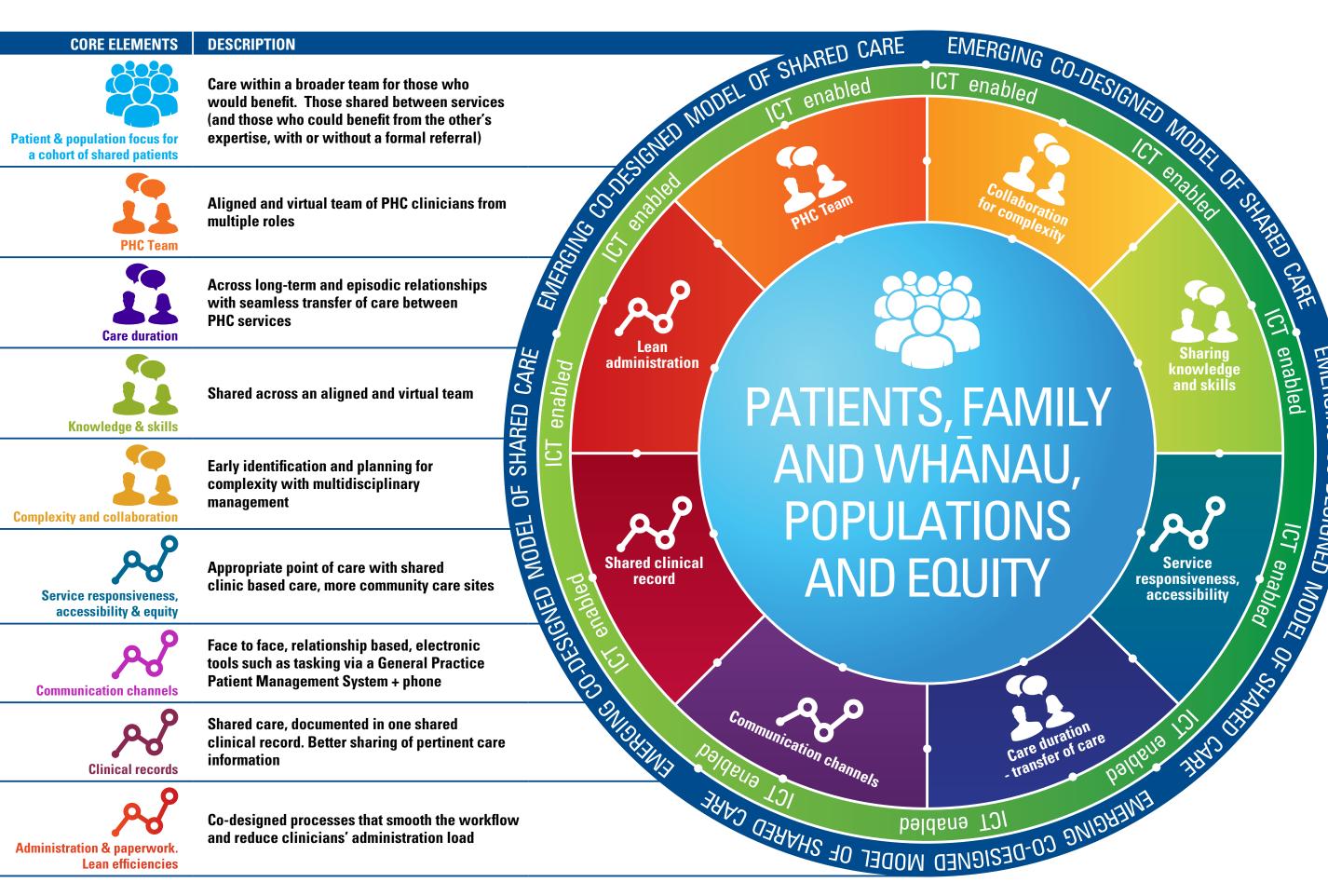
The Primary Health Care Nursing Integration project is a collaboration between the Central Primary Health Organisation (CPHO), the MidCentral District Health Board (MDHB) and primary health care services, all based in the lower North Island of New Zealand. The MDHB region covers a population of over 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.





Change Processes and Priorities 0

- \checkmark Relationships face to face meetings, patient care discussion opportunities
- ✓ Understanding other services (& how they work, what they do, what they need)

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.

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

OOLKIT COMPONENTS	ICT ENABLED				
Identifying patients shared between services	 Using the General Practice Team Patient Management system (GPT PMS) 				
Identifying clinicians involved in each patient's care. Flexible care coordination	for shared clinical records				
Flexible coordination of care, especially for patients with complex needs	• District Nursing Service (DNS) template for clinical records in the GPT PMS				
Shared care clinics for early referral, information sharing, seamless care transfer	 Remote District Nurse (DN) access to the GPT PMS 				
Nurse-to-nurse regular meetings, including attending General Practice Team (GPT) huddles	Communicating electronically for non- urgent matters				
PHC team involvement in MDT discussions, incl. specialist meetings such as Health of Older Person team	 Identifying other clinicians / roles involved in clinical records 				
Increased use of clinics for those able to attend	 A single patient focused plan of care (including for self management) 				
Home-based care when appropriate	Transfer of care to the GPT on DNS discharge				
Streamlined transfer of care processes					

- Accessing the GPT patient summary to provide advice at referral, earlier care via the MDHB portal
- Increasing supported self management A lower limb wound prevention and management health pathway
- patient outcomes, focusing on the right person with the right skills and Supported self-management plan knowledge providing care in the right discharge summaries for patients
 - Virtual consults
- complexity factors (research underway) Clinical photos
- Early transfers of care in all directions Standardised referral templates Local communication routines for the

- ✓ Streamlining processes & workflows
- \checkmark 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 4-5 times over the past 18 months for a. Post surgical wound dressing b. Lower leg eczema. Has another chronic condition, self 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 sign 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 given 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

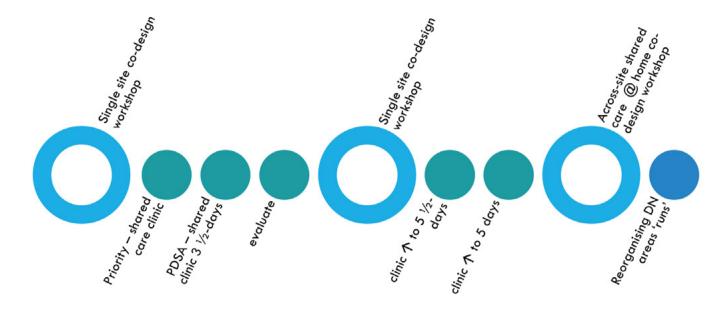
Doesn't have a written ongoing pla Do the GPs know what the DNs are doing? – No; Do the DNs know what the GPs are doing? – No

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 all 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 signing the prescription is. There is no continuity of care. I don't know who my GP is.

	An active life, including caring for a family member for over a decade		DN clinic visits for leg dressings Referred for Doppler Advised to wear compression stockings		The Practice Nurse sent me to the District Nurses due to the cost. If I go down there [to the GPT] I have to	Irse sent the to the District Trees due the cost. go down the cost. go down the cost. go down the cost. go down the paying. this I paid 5.00. Even they put a nd-Aid on they put a nd-Aid on twe to pay. the District Nurses Iy had to thess it from the ankle andage m toes to the cost to the c	Referral to District Nursing	I'm not sick so that's why I go down to them [clinic], I am quite able to. There is probably someone out there that needs them to go to them more than I do. Set appointment times work – time doesn't bother me. Visit twice a week, usually a Tuesday & Thursday. I take the bandages off, have a shower & go down to the clinic & they put the dressings on	My feet hurt, especially whe I'm walking. I ca only walk abou 10 minutes befo my calves & feu get sore & I nee to come home There doesn't seem to be mud I can do, I can do the gardonic
ATIENT MILESTONES	l've had eczema all my life. As I have got older it has got worse, on the bottom of my feet & legs – it makes me feel yuck, I'm over it. When it breaks down & is weeping I don't like people seeing them.	Refer to District Nursing	I saw another nurse for a Doppler & she suggested UV light for the eczema – I'm still waiting for the appointment. I used to go to the sun bed & my [previous] GP knew & my legs were good then.	Skin cancer taken off lower leg [under local] – they were going to do a skin graft but they didn't, they just sewed it up	keep paying. I think I paid \$35.00. Even if they put a Band-Aid on I have to pay. The District Nurses only had to dress it from the ankle up [usually bandage from toes to knee]. My eczema was breaking out again but they wouldn't treat that as well – 'because that's not on the referral'. The District Nurses came home for a while because I couldn't weight bear.				do the gardenii any more – I ha to pay someon I like to get ou & do things & it's stopping m This one aches this leg is painf I feel there is nothing else thi can do for their I like looking nii & then I have to wear these stockings – th DN said 'don't I vain' – but I like look after myse these stocking all the time & w summer comin my feet swea

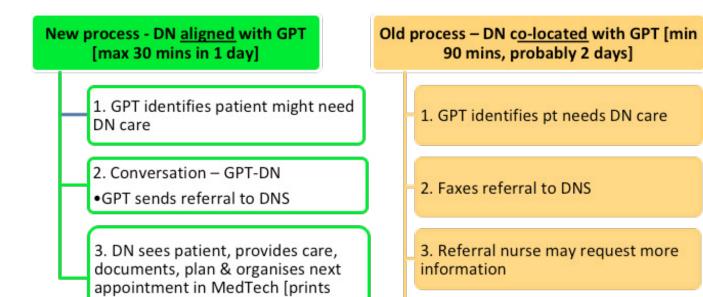
Objectives were to:

- 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



PHC team	for GPTs
Reduced care documentation processes for District Nurses	 Automatic acknowledgement of referrals received by the DNS
 Link roles for smaller practices Increased service level relationships 	 GPT alerts to DNs for events with shared patients, such as hospitalisations or deaths

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

at referral when appropriate

place at the right time

Better understandings of patient

Skills and knowledge shared for better

- ✓ 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
- \checkmark 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 0
 - Reorganising the District Nursing workforce for complexity 0
 - Scaling to the wider PHC nursing workforce 0
 - Testing other degrees of alignment across the range of 0 numbers of shared patients between services.

CONCLUSION

'The wider General Practice &

District Nursing Teams worked

together really well. They all had

access to all the information they

backup of GPs as necessary'

[Patient interviewed as part of

clinic evaluation

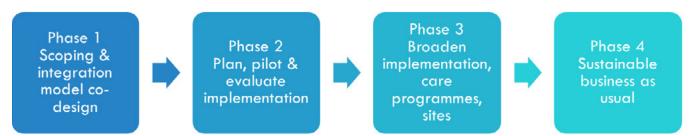
eeded & the District Nurse had the

This project is work-in-progress. It demonstrates the positive impacts of following co-design principles to address widely

Implementation was designed to be completed in 4 phases.

TIMELINE

January 2016 January 2017



January 2018

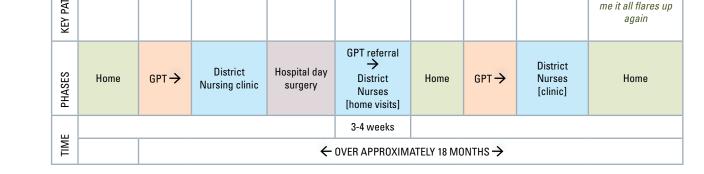
PHASE ONE

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

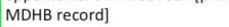
- Interviews Mapping patient journeys
- Data & document analysis Observations
- Focus groups
- Considering national & international lessons

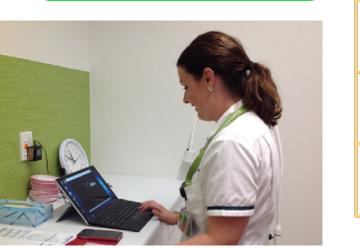


• Key findings Phase 1

Patient focused care but:

- ✓ Busyness & heavy task workloads
- \checkmark 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
- \checkmark Co-location \neq integration





7. Writes note / faxed to GPT

travel]

4. Arranges to see pt tomorrow

5. DN home visits [1 hour visit +

6. Arranges next appointment

- Shared care clinic outcomes trust, team, teamwork
- ✓ Patient choice opportunity costs
- ✓ Time released to care
- ✓ Earlier interventions
- ✓ Appropriate, timely referrals to other services
- \checkmark Patients know team (& know the wider team knows!)
- ✓ Reduced requests for patient details
- \checkmark Plan of care in notes, identical plan given to patient
- ✓ Staff satisfaction

✓ Seamless transfers...

'This has been of enormous benefit to Kauri Healthcare patients. I wish to thank [District Nurse] for all the advice and support she has given me. Thank you [KHC staff survey for clinic evaluation]

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 servicelevel relationships have been developed, and patient and family focused solutions are informing all future developments.

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