Integrated Family Health Networks

NZHHA Conference, 2 September 2010

Healthcare NZ

good to be home

- 20 year track record
- 40 branches throughout NZ
- 6,500 staff, ~6m hours of support/annum
- Services include:
  - Home-based support
  - Community Nursing
  - Intellectual and physical disability support
  - Chronic care management
  - Telehealth

Home health services are changing…

Today

- A burning platform
- The theory
- Making it real

The lay of the land…

- Can't afford to build more hospitals:
  - How do we do a better job of keeping people out?
- We need a new venue for care delivery:
  - By 2015, the home will be the hub of care*
  - How do we maintain wellness at home?
- Fewer doctors and nurses:
  - But is there a broader workforce that can be utilised?
- Patients/clients are expecting more
  - Increasingly driving their own care

** Naomi Fried, VP Kaiser Permanente*

Complexity and Cost

	% People	Relative risk of emergency admission	Percentage of Cost*
Advanced Clinical Services: CASE MANAGEMENT	0.5%	VERY HIGH	39%
Nursing and Rehabilitation: DISEASE MANAGE-MENT	0.5 - 5%	HIGH	35%
Home Support: SUPPORTED SELF-CARE	6 – 20%	MODERATE	26%
Prevention & Wellness Promotion	21 -100%	LOW	

Source: The King's Fund, UK, 2009

Better, Sooner, More Convenient?

Government looking for rapid progress on BSMC:

- Patient-centric services and systems
- Coordinated care closer to home
- Shifting of services into the community
- Delivery of measurable outcomes
- Reduced demand on hospitals
- Workforce supply meeting demand
- Public/Private partnerships

Source: Better, Sooner More Convenient, Health Discussion Paper, 2008

Evidence

Integration -

- reduces admissions to hospital
- reduces bed occupancy
- closer working between health and social care
- a more responsive service
- closer working within the primary care team
- improved primary-secondary interface
- easier access to services for patients and carers

Integrated Care: Critical Enablers

Evidence
1. Standardised Assessment
2. Proactive Care Coordination
3. Consistent Care Pathways
4. Integrated Information Systems
5. Workforce Redesign
6. Aligned Financial Incentives

Source: LECG analysis, 2009

Making it real

Kawerau and Turangi proof of concepts:

- Service model
- New system capabilities
- Trained workforce

Integrated Family Health Network:

- Focus
- Principles
- Enablers

Kawerau pilot

Series of implementation activities

- Develop community health worker-led (~*kaitautoko*) model, supported by nursing governance
- Develop NZ's first 'off-the-shelf' training package in chronic condition management for community health workers
- Relationship building with established health and social providers

Kawerau pilot

Team Structure:

- 1 Registered Nurse
- 2 Kaitautoko

– All team members are from the local community

– Operate as part of general practice teams

Marcus (Kaitautoko), Ngaire (RN), Nancy (Service Manager), Wilma (Kaitautoko) and Lewis (KPHO)

Kawerau results

On discharge:

- Clients indicated confidence in being able to manage their condition and being aware of services to access if required
- 69% clients stated health had improved by being part of the service
- The most beneficial components were:
  - 41% - coordination of services
  - 32% - increased knowledge to manage their condition
  - 9% - having whānau involved in process and service

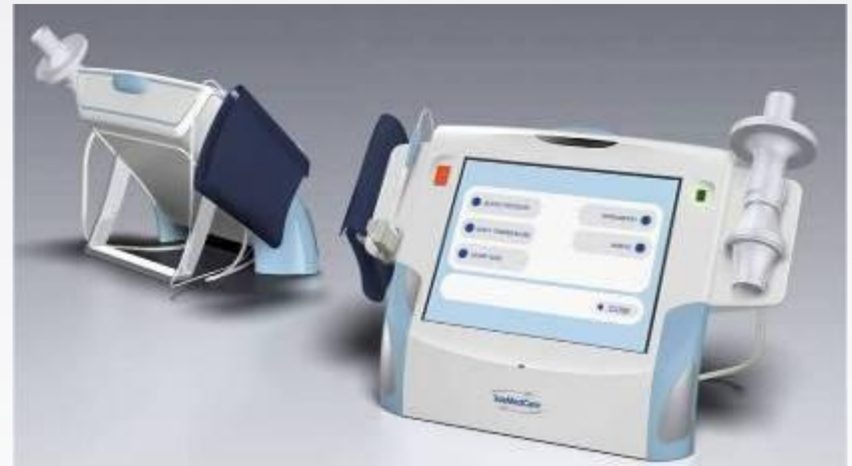
Lakes telehealth pilot

Partnership with Lakes DHB and Lake Taupo PHO:

– Turangi and Taupo
– 20 COPD & CHF clients discharged from Lakes and Rotorua hospitals randomised to telehealth intervention or control group
– Existing chronic care management programme with PHO Family Nurse activity
– Both groups received the chronic management programme HealthRight
– *Vision to reduce demand on hospital services*

Telehealth?

- Application has to be stratified: complex, 'frequent flyer' vs single disease state
- The TeleMedCare desktop application is tailored to patients with complex needs
- Single, shared or mobile use
- Individualised trends and alerts setting



Telehealth technology enables people to monitor their own heart rate, blood pressure, lung function, weight, temperature, health diary and questionnaires from home.

Lakes telehealth results

The telehealth clients had decreases of:

- for **COPD**: 13% in ALOS; 20% in AHA
- for **other conditions**: 93% in ALOS; 63% in AHA
- in **COPD** 49%; in **other conditions** 100%; and in **all causes** 59% in average ED attendances

ALOS = average length of stay

AHA = average hospital admissions

Lakes telehealth results

"The machine tells me a lot. I am more alert and on to it around everything. It has changed how I manage my condition e.g. eating 3 cream buns versus 1 cream bun, I see my blood sugar are not as up as much."

"It has changed not only my medical condition, but changed my life in general, mental and physical. I have a totally better outlook."

"I look at my measurements and know it will be a huffy puffy day"

Bringing it all together

- Chosen as one of 9 successful BSMC business cases in Eastern Bay of Plenty
- Partnership between 3 PHOs, Bay of Plenty DHB, National Maori PHO Coalition, HCNZ
- HCNZ contribution is the Integrated Family Health Network I Te Whiringa Ora
- Incorporates governance, contracting, financial, service and resourcing models of previous pilots

Integrated Family Health Network

Focus -

- Regional coordination and navigation for complex top 5%
- Case Coordinator/Manager (with RN/Social Worker skills) and Kaitautoko
- Early Supported Discharge, Telehealth and Urgent Community Care

Guiding principles -

- Consistent assessment and care planning
- IFHN as an integrator and coordinator
- Add value to existing provider ecosystem
- Clinical pathway enabler
- Whanau Ora orientation
- Repeatable platform for future services

Enablers -

- Standardisation: series of 7 high-level processes
- Range of supporting processes, tools and technologies
- Integrated IT platform enabling shared view of assessment and care planning information

High Level Processes

BUSINESS PROCESSES – EBOP INTEGRATED FAMILY HEALTH NETWORK

HIGH LEVEL PROCESS OVERVIEW

High Level Processes

"Ensuring patients receive the right level of care by the right people at the right time"

"Patient pathway starts"

Referral Management → Navigation → Coordination ↔ Delivery ↔ Review → Transition → Discharge

"Patient ready to self-manage"

"Patient pathway ceases"

Core Processes

- Patient entry and referral processing
- Assessment and care planning
- IFHN coordination planning
- Deliver patient care/support
- Evaluate patient ability to self-manage
- Community case management
- Receive and process discharge

Supporting Processes

- Clinical Governance
- Reporting
- Quality, Policies (OSH)

Visually

SINGLE POINT OF ENTRY

General Practice

Hospital

Iwi Providers

Integrated Family Health Centre

Self-Referral

Referral

INTEGRATED FAMILY HEALTH NETWORK

INTERVENTION / STABILISATION

SINGLE POINT OF NAVIGATION AND COORDINATION

Case Management
Case Coordination

Early Supported Discharge
Rapid Response
Telehealth

New Needs

Transition

MAINTENANCE

SELF MANAGEMENT

Community Based
Case Management

SINGLE PATIENT CARE PLAN

SERVICE PROVIDER ECOSYSTEM

DISCHARGE

IT Platform

Patients

View/update
Care plan

Web
Portal

Navigation
Coordination

Telehealth

Minimum
data set

Single
Care Plan

Reporting

GPs

E-referrals

Hospitals

Rostering

Invoicing

External Service Providers

In summary

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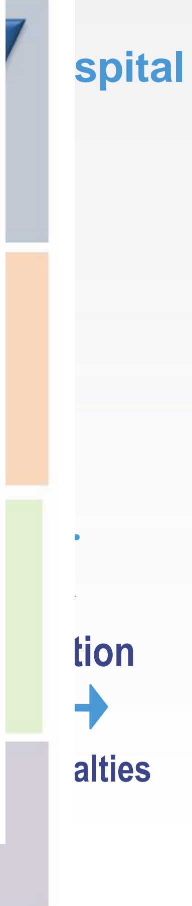
Promotion



Source: The King's Fund, UK, 2009

Questions