CentralPHO

COLLABORATIVE TRIAGE OF REFERRALS

Dr Helen Snell, MDHB & Christine Hill, Central PHO

DIABETES LEADERSHIP GROUP

- An intersectoral MidCentral district group consisting of primary & secondary diabetes clinicians, NGO, management, Iwi/Maori providers & consumers

- To take leadership for development of the Diabetes Partnership Framework & move towards a patient experience with a one system approach

DIABETES LEADERSHIP GROUP

- Four key features of the partnership framework are:
  - Lead: Local Leadership Group overseeing, developing & monitoring services & outcomes & taking a “Champion” role for diabetes
  - Join: Joined up services to create the impression of one District wide service from a consumer point of view
  - Flex: Working in, between & across various teams to have the right skills in the right place
  - Act: Instituting agreed activities to improve services and demonstrate partnerships
- The Diabetes Collaborative Triage Project emerged from the Diabetes Leadership Group

DIABETES COLLABORATIVE TRIAGE PROJECT TEAM

- Diabetes & Endocrinology Service, Mid Central Health
  - Helen Snell – Nurse Practitioner
  - Shelley Mitchell – Diabetes Specialist Dietitian
  - Alison Fellerhoff – Clinical Nurse Specialist
  - Owais Chaudhri – Endocrinologist
- Central PHO
  - Pauline Giles – Nurse Practitioner (now Whanganui DHB)
  - Lois Nikolajenko – Clinical Nurse Specialist – Diabetes
  - Julie Berquist – Community Clinical Nurse-Long Term Conditions
  - Dee Rixon - Community Clinical Nurse-Long Term Conditions
  - Linda Dubbledam – Clinical Director (Manager Innovation & Development, HBDHB)
  - Caroline Clark – Clinical Services Manager/Christine Hill – Clinical Development Manager
  - Kirsty Dunlop – Project Manager

COLLABORATIVE TRIAGE OF REFERRAL

- Single combined referral criteria was developed & agreed February 2017
- Weekly collaborative triage of referral meetings were established March 2017
- Nurses & dietitians from primary (PHO/IFHC) & secondary care (Podiatrist & Endocrinologist when able) across the DHB region attend
- All referrals received are discussed providing a single point of triage for diabetes services
- Patients are discussed & allocated to appropriate service & a key worker CNS/DSD or CCN-LTC
- Documentation captures patient service destination

PATIENTS ARE SEEN BY THE RIGHT SERVICE FOR THEIR NEEDS

- Within the individual services there will be a robust triage process to ensure the right clinician/s with the right skills is allocated to assist that particular individual
- At the meeting, eligibility of a patient' referral to specific services will be discussed and allocated accordingly

Clinician survey feedback:
"Great being able to discuss some people who do not easily fall into defined criteria and determine where their needs best fit"

"There has some re-engagement of people with type 1 diabetes with secondary care services, which is really helpful"

MORE EFFICIENT REFERRAL FLOW

- The referral meeting will provide a mechanism for smooth transfer of care for patients discharged from hospital requiring follow-up via primary health care nursing & dietitian services
- It will also provide a smooth transfer of care for outpatients inboth directions between primary & secondary care services.

Clinician survey feedback:

"I think the collaborative triage meeting has significantly improved the efficiency of referral processes for people with diabetes requiring primary care follow up after their inpatient stay"

CLINICIAN SURVEY GEMS

"A nice collaborative approach & strengthening relationships with our primary care colleagues"

"Meetings have allowed for face to face handover whereas previously we had to email individual CNSs to see if they had received a referral for people admitted to hospital"

"Attendance of the podiatrist has highlighted & encouraged the importance of the urgent referral for the person with high risk feet from primary care"

"The weekly meeting has facilitated stronger communication & relationships between primary & secondary care which will have a positive impact on care delivery for our patients"

OUTCOMES

- Weekly referral meeting provides a mechanism for collaboration, communication, working together & a joined up approach
- Transparent and timely referral processes
- The system appears seamless to the patient
- Strengthened understanding of each others' roles, trust & relationships
- Improved knowledge of services available & who is based where
- Freer communication between services
- Enables clinical discussion providing learning opportunities
- Referral framework has provided clarity for general practice & others referrers

CRITICAL SUCCESS FACTORS

- Courage to confront myths & perceptions
- Clinician & clinical manager leadership of the process
- Respectful dialogue
- Active management of expectations
- **Agreed referral criteria framework**
- Clarification of roles/scopes/responsibilities
- Having different disciplines around the table

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- Videoconference facilities to reduce travel time
- Inclusion of Iwi/Pasifika nurses, PHO dietitians……
- Case review opportunities