Making a Dent in SLMs

Through interdisciplinary coordinated care models of working

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System Level Measure - Using Health Resources Effectively

How do we reduce our ASH 45-64?

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LONG TERM CONDITIONS FRAMEWORK

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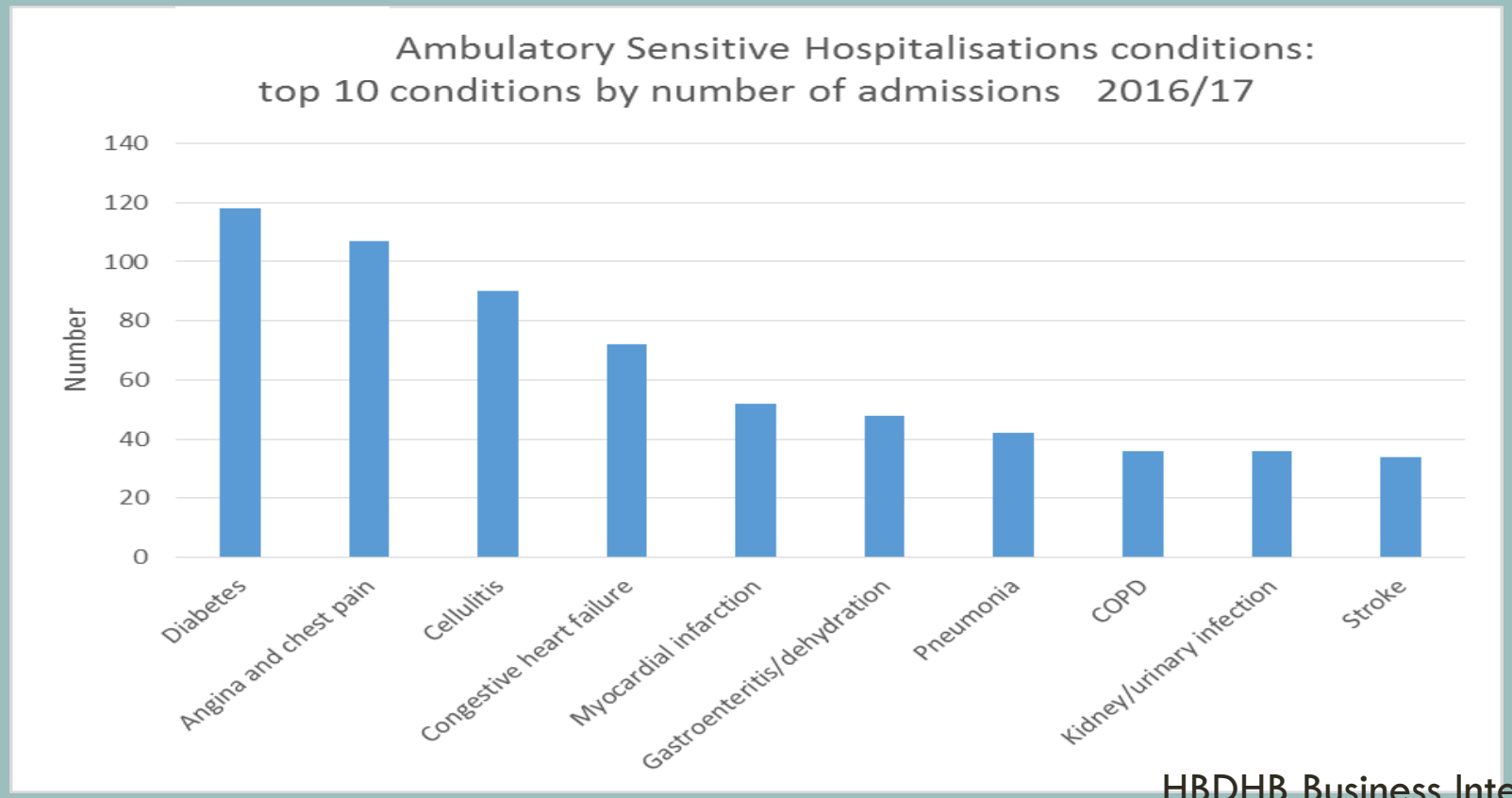

HBDHB Business Intelligence Team

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And…

- Anticipated 7% exponential increase in diabetes
- 15% population with 2+ co-morbidities
- 80% of spend on Long Term Conditions on acute and rehabilitative services
- Health Round Table data shows 33% of HBDHB Acute Hospital Bed Days are related to LTC

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Long Term Conditions Framework

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The framework shifts focus from …

individual disease **to the individual person/whanau**

care delivery **to care coordination**

clinical impacts on health **to the impacts of the determinants of health on wellness**

symptom management **to prevention and early intervention**

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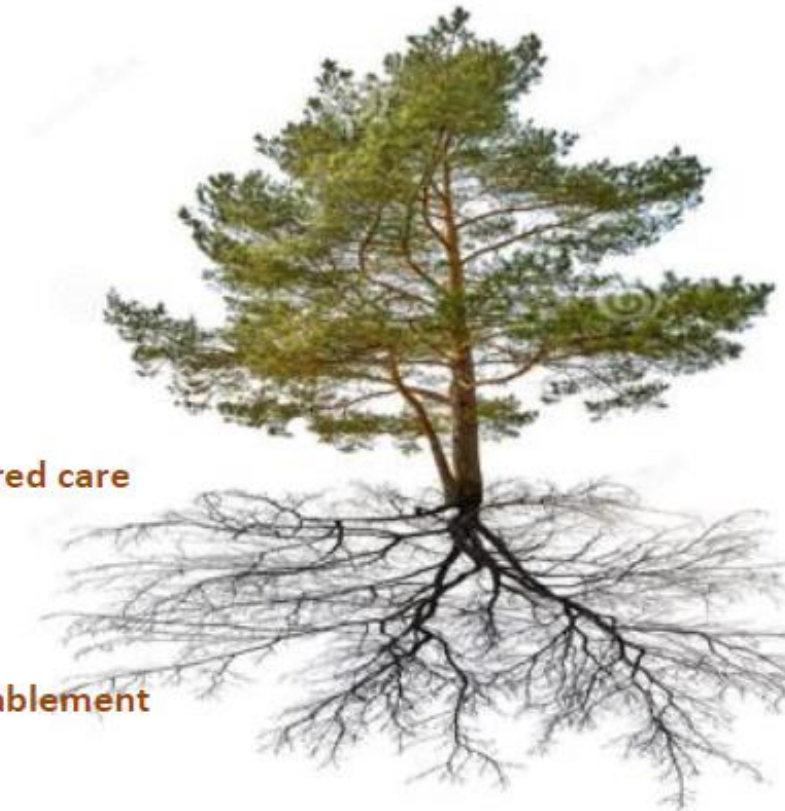
Hawke's Bay DHB
Long Term Conditions (LTCs) Framework



Person- family - whānau centred care

Person centred systems and processes

Workforce development and enablement

Risk identification and mitigation

The Kahikatea[1]

The Four Aka

Person - Family - Whānau Centred Care

- Consumer voice
- Health Literacy
- Self-Care
- Understanding the determinants of health

Person Centred Systems and Processes

- Care Coordination
- Transition of care
- Collaborative clinical pathways
- Integrated IT systems and enablement

Your Health in Your Hands with Our Help and Support

Kei a koe te tikanga

Workforce Development and Enablement

- Workforce capacity and capability
- Clinical Leadership
- Clinical expertise
- Inter-sectoral development

Risk Identification and Mitigation

- Population health
- Equity
- Continuous quality improvement
- Governance and advisory support

The LTC - Service Review Matrix

- Is a strengths based approach to improvement
- Uses IHI Improvement methodologies and Results Based Accountabilities
- **Supports directly work already being done**
  - NZ Health Strategy (LTC- Dimensions)
  - Local DHB Strategies (HBDHB Transform and Sustains Outcomes)
  - Cornerstone Achievement Objectives (Primary care)
  - Quality planning and service planning
  - Individual to each service unit but uniform across the whole system

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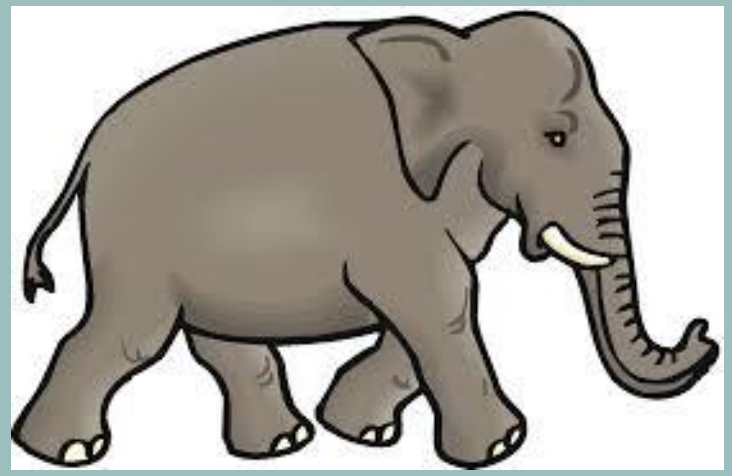
Excellence		Improvement		Entry	
6	5	4	3	2	1
Services exhibit a systems wide approach and can be recommended as champions **to lead in All Dimensions within the Aka**		A service that is functioning at this level exhibits good practice in most areas and has evidence to support their **working towards a consistent system wide approach across most of the dimensions within the Aka**		A service that is functioning at this level exhibits areas of **good practice but this is reliant on individual staff vs a consistent system wide approach.**	

1. Think of a service you are involved with
2. Using the global indicators how would you rate that service against the dimensions in each Aka?

	Excellence				Improvement				Entry							
	6				5				4				3			
	Aka One				Aka Two				Aka Three				Aka Four			
	Person Family -Whanau Centred Care				Person Centred Systems and Processes				Workforce Development and Enablement				Risk Identification and Mitigation			
Service (Unit)	Consumer Voice	Health and Literacy	Self Care management	Determinants of Health	Care Coordination	Transition of Care	Collaborative Pathways	Integrated IT Systems	Workforce capacity and capability	Clinical Leadership	Clinical Expertise	Intersectoral Collaboration	Population Health	Equity	Continuous Quality Improvement	Senior Clinician Forum



The LTC Elephant

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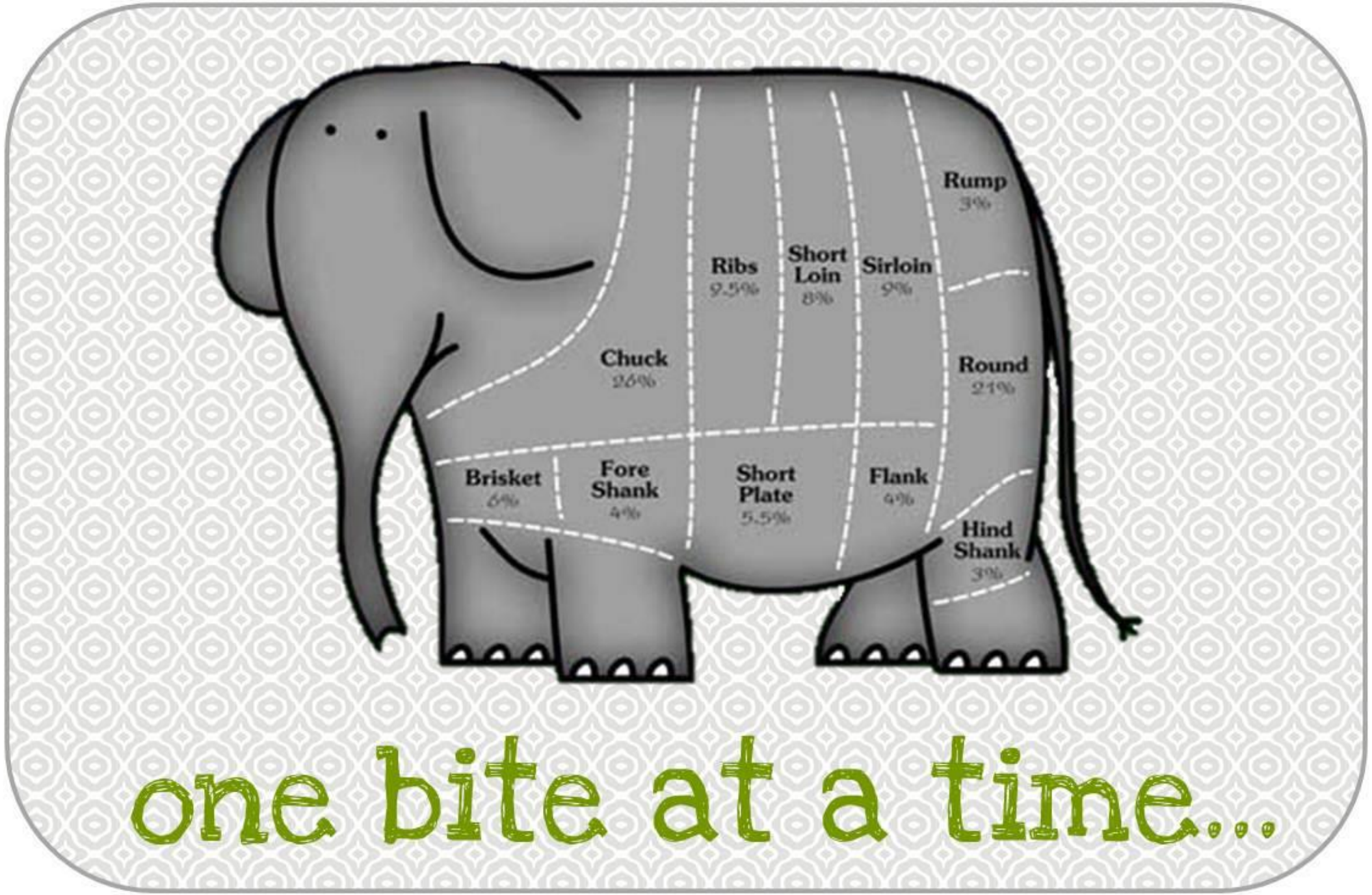
Rump
3%
Ribs
9.5%
Short Loin
8%
Sirloin
9%
Chuck
26%
Round
21%
Brisket
6%
Fore Shank
4%
Short Plate
5.5%
Flank
4%
Hind Shank
3%
one bite at a time...

The Four Aka

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Aka Two	Person centred clinical systems and processes						Evidence
	Excellence		Improvement		Entry		
	6	5	4	3	2	1	
Care Coordination	• Care coordination processes are regularly analysed using agreed methodologies e.g. Tracer audits, patient interviews • Findings from above are used to inform CQI initiatives. • Readmission rates & acute presentation rates are used to inform CQI initiatives and evaluation of same. • Effective care coordination is evidenced in patient experience survey results		• There is a single (and or multi-disciplinary) assessment/planned care framework for the person • The person nominates key health leads within their team for the coordination of their care • The intent of care is to focus on "what really matters to the person vs what's the matter" • There is evidence of detailed coordination within transfer of care planning and implementation.		• Care coordination processes are in place • A complete history has been recorded inclusive of all aspects of the person's wellbeing (holistic) and the team appropriate to their care has been assembled. • The person identifies with key health leads within their care team. • Person verification is evidenced (relationship centred care approach).		**Patient experience surveys DNA rates ED Presentations Acute presentations Readmission rates ALOS (acute)**
Transition of care	• Shared care record is used by all staff /providers involved in care provision of the consumer. • Tracer audits are used routinely to improve the person's transition of care. • Peer review forums organised by the service to share learnings from CQI initiatives.		• Tracer audits of patient journey through the health care system are used to inform improved transitions of care. (CQI initiatives) • The tracer audit team is multidisciplinary and includes consumers • Complaints registers analysed for trends in; Clinical administration-Process-Transfer of care (WHO Taxonomy Patient Safety).		• Transfer/discharge summaries from/to providers is reviewed against the following criteria; - timeliness, - order of information, - quality of information - health literacy (consumer) • Tracer auditing training has been completed by service leaders (HQ&SC).		**Patient experience DNA rates Discharge documentation Incident / adverse events register**
Collaborative Practice: • Pathways • CPO	• It is demonstrated through the E-referral processes that staff are utilising the collaborative pathways as the tool to guide what is required in a referral • Corrective actions are put in place to improve utilisation of the CPO programs.		• Evidence shows that staff are utilising the collaborative pathways for continuity of care and align with clinical guidelines. • Services analyse ED presentations and admissions to evaluate the effective use of CPO and Pathways.		• There are pathway and Coordinated Primary Options (CPO) champions within each service who assist in the development and socialisation of same • Staff training and support is provided to ensure maximum uptake and promotion of these programs.		**Uptake of pathways Treatment management adherence ED referral and admission rates ASH rates**
Integrated IT systems	• Improvement cycles support the inclusion of new technology based on robust evidence of efficacy.		• PMS support; single repository for patient information • PMS support electronic functionality across and between providers e.g. e referrals, e records, remote access of multi-providers.		• The quality of information entered into the Patient Management Systems (PMS) is monitored and staff training provided to address inconsistencies.		**PMS Data integrity Uptake of e systems**

Examples of care coordination – transition of care

Led by Respiratory (Cardiac) service

Focus: Early diagnosis, appropriate management, Self Care - Self Management,
Services: Respiratory physicians, CNS workforce, Primary Care, ED, St John, Stanford, Breathe Hawke's Bay, Pharmacy
Outcomes: Decreases in ED presentations, hospitalisations and length of stay.
Next steps: Focus on Māori and Pasifika (whanau based care)

Led by Diabetes/Renal service

Focus: use of specialist workforce in community and primary care settings
Services: Diabetes Centre -DHB, CNS workforce, Renal team, QIAs, Primary Care (incl. of PHO)
Outcomes: reduced FSA by 26%, primary care lead insulin initiation.
Next steps: Greater care coordination in inpatient services (Aka 2 and Aka 3) with a focus on readmission rates

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Service 1																
Service 2																
Service 3																
Service 4																
Practice A																
Pratice B																
Practic C																

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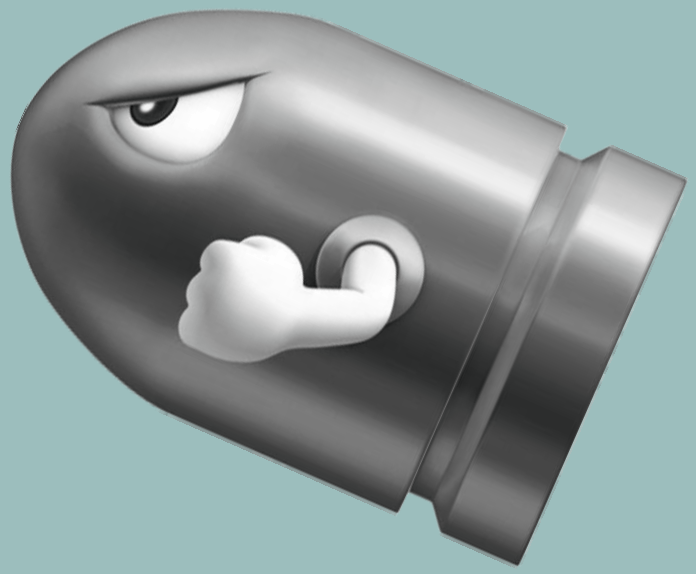

Lessons learnt

No silver bullet

WIIFM – really important

Linked to and supports existing work

Highlights / spotlight on success and strengths

Needs a Facilitated Process

Tracer audits – real gems!!

Bit sized pieces

Keep it small and simple

And we are on a journey of discovery

But with a fuel tank measuring how far we have travelled and a diary recording our journey

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