Te Akatea Transitional Care Team

Travelling the journey with our patients and whānau

PHASE ONE
THE TRANSITIONAL CARE NURSING SERVICE

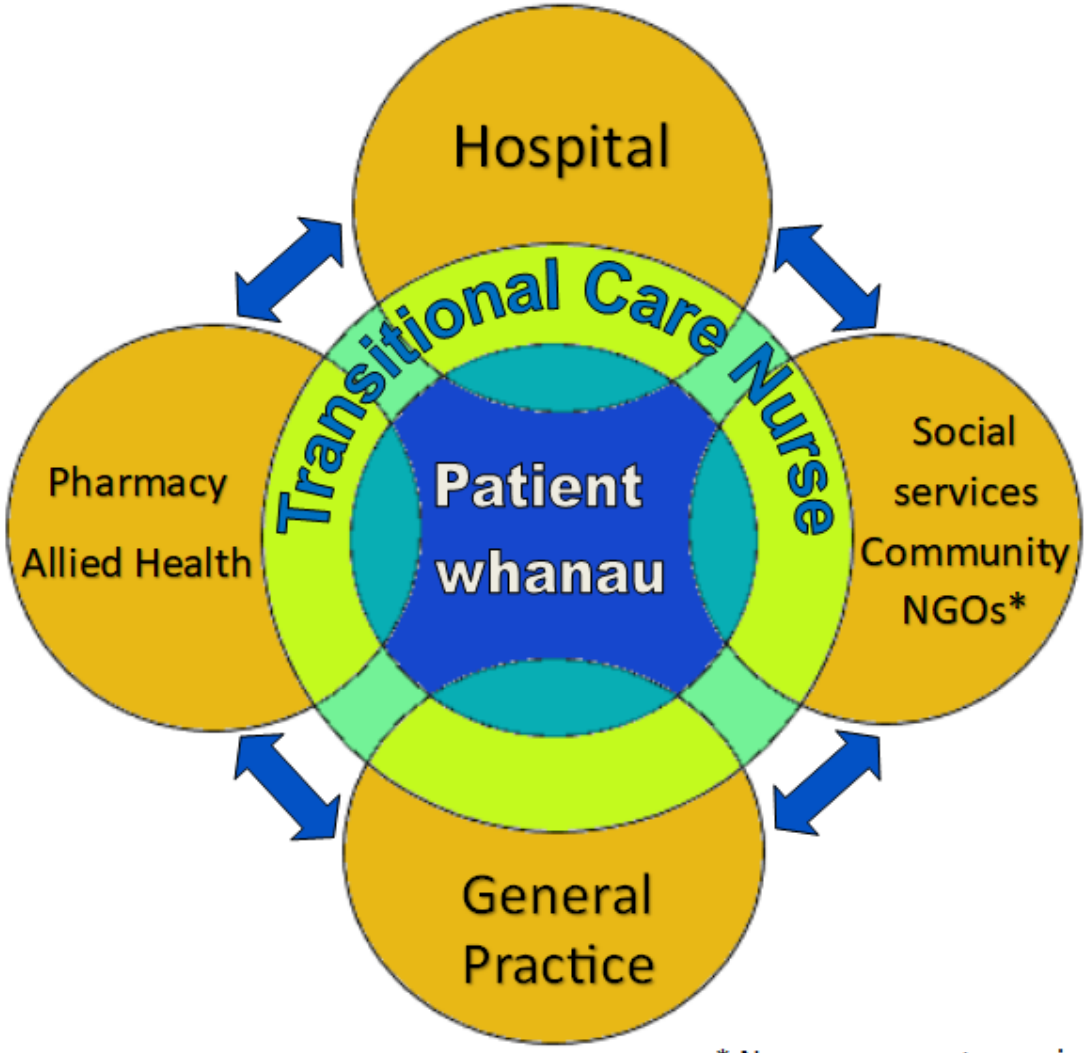
Influenced by:

Wagner's Chronic Care Model

The New Zealand Triple Aim

Kaiser Permanente Triangle of Risk

Graphic credits: N Macklin, H Pert, T Dowell



* Non-government organisations

TRANSITIONAL CARE NURSING SERVICE AIMS AND OBJECTIVES

- Greater support for patients to self-manage their health journey
- Enhanced safety and quality of patient health services
- Improved service efficiencies
- Promoting equity in access to health services

PHASE ONE QUANTITATIVE EVALUATION RESULTS (2016-2018)

8% reduction in acute hospitalisation rates

197 patient contacts per month on average

Māori, elderly, and socioeconomic deprivation quintiles 4 and 5 were represented at a higher rate in the service population

PHASE ONE QUALITATIVE EVALUATION RESULTS

Macklin, N. (2018). Hearing the patient voice: The importance of caring in care (Thesis, Master of Primary Health Care). University of Otago.

Being sick and receiving treatment makes us **vulnerable,** regardless of age or social support.

Kindness, compassion, communication, and accessibility of those delivering our treatment makes a significant difference to our experience, recovery and wellbeing.

We judge our experience of the care episode not on the facts of the care, but on the level of **caring** that we perceive is being extended to us.

PHASE ONE IN SUMMARY…

Improved patient experience of overall care

Increased health literacy and confidence to self-manage their conditions

Appropriate medications usage and regime adherence

Improved family and whānau experience and support

Enhanced sense of control and engagement

Supported wellbeing - feeling cared for, listened to and respected

PHASE TWO
TE AKATEA TRANSITIONAL CARE TEAM

Operating since 2018

Differences:

- Introduction of Pou Awhina role to the team, as well as consulting clinical pharmacists.
- Testing the scaling up of model and narrowing the focus by reducing the access point.
- Collaborating with the PHO's (RAPHS) Extended Care Team to provide expanded services to four general practices currently, with another two in development.

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PHASE TWO
TE AKATEA TRANSITIONAL CARE TEAM

- The service aligns with Lakes DHB strategic directions and has an emphasis on decreasing inequity, addressing acute demand, as well as supporting integrated care.
- The introduction of the Pou Awhina role in Phase Two acknowledges the significant interplay between clinical, physical, social, cultural and whānau influences on health and wellbeing. The role brings a deeper layer to the patient-centred and whānau-centred goals of the service.