Integrated Services – Driving Change

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What Drives Change?

- Escalating costs
- Decreasing demand / changing market
- Increasing demand
- Increasing competition
- New technology
- An external event (like, maybe, an earthquake?)
Canterbury’s Story – The Way We Were

• Increasing demand and rising costs
  – Aging population
  – Aging workforce
• Difficult to access specialist services; long wait times
• Earthquakes!
  – Diverse population
  – Rebuild/construction
  – Mental health
Respiratory

- A health system which encouraged people to go to hospital

5.1.2 COPD hospital admission rates, population aged 15 and over, 2009 (or nearest year)

Note: Rates are age-sex standardised to 2005 OECD population. 95% confidence intervals are represented by 1—1.

Source: OECD Health Data 2011.
Building a System-wide Vision

• Look at the data
  – Forecasting and analysis
  – What’s the problem?
• Engaging
  – Conversations; brainstorming
  – Building relationships
• Leadership
• Sharing the vision
  – Draw the burning platform
  – Making it better for ‘Agnes’
• Enable a new way of working – alliancing and integration
Enabling Change

• A new way of decision making

- You decide
- We discuss, you decide
- We discuss, we decide
- We discuss, CDHB decides
- CDHB/Minister decides
Our Vision
Three Strategic Goals

People take greater responsibility for their own health

- The development of services that support people/whānau to stay well and take increased responsibility for their own health and wellbeing.

People stay well in their own homes and communities

- The development of primary care and community services to support people/whānau in a community-based setting and provide a point of ongoing continuity, which for most people will be general practice.

People receive timely and appropriate complex care

- The freeing-up of hospital based specialist resources to be responsive to episodic events and the provision of complex care and support and specialist advice to primary care.
Outcomes
System-wide Results

• Acute medical admissions lowest of any large DHB (70% of national rate)

• Reduction in people living in aged residential care
  – People receiving more home-based support means more people are supported to regain and retain their independence at home

• New technology

• New models of care – Collaborative Care and IFHS

• New supported discharge programme – CREST

• Reduction in falls, and many more examples
Integrated Respiratory Services

• HealthPathways
• COPD Pathway
  – Admission avoidance/reduction
  – Case finding and sentinel events
• Community Spirometry
• Community Sleep Assessment
• Pulmonary Rehabilitation
• Links with other services
  – Acute Demand
  – Collaborative Care
  – Integrated Family Health services
Keeping well with COPD
Chronic Obstructive Pulmonary Disease

Key steps to stay well and keep out of hospital
(Keep this in easy reach, e.g. on the fridge or with your medicines)

1. Make sure you do not run out of your medicines

2. Watch out for:
   • More cough, wheeze or breathlessness than usual
   • Needing to use inhalers more than usual
   • Fever or feeling tired and unwell
   • Change in the amount or colour of your sputum/phlegm

3. If you have any of the above problems contact your GP
   You may need an appointment to be reviewed by your GP.
   Phone your GP..........................................................

4. If you have fever and/or yellow/green phlegm:
   Don’t delay, start antibiotics if you have been prescribed these
   Name of medicine .........................................................
   Dose..............................................Prednisone dose..........................

5. If you are very short of breath when you are sitting or lying
   If you are feeling very restless or drowsy
   Call your GP for an urgent assessment or call 111

2012 Plan for People with COPD

Your COPD Information
(Your GP can fill in this information with you)

If you require medical attention it is very useful for medical and ambulance teams to know how your breathing is when you are well.

Name:
Address:

PO2 when well:
Normal exercise tolerance:

CO2 retainer: Yes ☐ No ☐ Unknown ☐

Special notes or requirements:

Date card completed:

To learn more about your COPD look at www.healthinfo.org.nz
## Ambulance COPD Risk Stratification

<table>
<thead>
<tr>
<th>GCS</th>
<th>Mild</th>
<th>Moderate (ANY OF)</th>
<th>Emergency (ANY OF)</th>
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</thead>
<tbody>
<tr>
<td>Talking</td>
<td>Sentences or phrases</td>
<td>Phrases</td>
<td>&lt;14 Drowsy/Confused/Comatose</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Words or Respiratory Arrest</td>
</tr>
<tr>
<td>Temperature</td>
<td>Afebrile</td>
<td>Afebrile or low grade fever (&lt;38)</td>
<td>Febrile (&gt;38)</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>&lt;20</td>
<td>21-30</td>
<td>&gt;30 or Respiratory Arrest</td>
</tr>
<tr>
<td>Oxygen saturations</td>
<td>Within 5% of known 02sats when stable AND Above 88%</td>
<td>5% below known stable 02sats OR Below 88%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Examination consistent with COPD, with no other concerning features</td>
<td>Any feature not consistent with COPD</td>
<td>Hypotensive/Shocked/BP &lt;100 systolic</td>
</tr>
</tbody>
</table>
| Pathway recommendation | • Aim to manage at home  
• Link with GP in first instance  
• Referral to ADMS for RN visit within 4 hours  
• Patient advise: If unwell before RN visit to call 111 | • Transport to 24hr Surgery  | • Transport to CHCH ED                   |

*Canterbury Clinical Network*

* v1 May 2012
Working with Ambulance

COPD Ambulance Calls and outcome

- Ambulance Treated in Community
- ED
- Total Ambulance Calls

Canterbury Clinical Network
Community Spirometry Tests

• >6,234 spirometry tests done in the community since 2009
Community Sleep Assessments

- >5,435 sleep assessments done in the community since 2009

Community Sleep Studies

2009 2010 2011 2012 2013 2014 2015 (partial)
Pulmonary Rehabilitation

• 9 programmes run in 2014-15 at 7 different community venues including rural
• >3,000 referrals to Pulmonary Rehabilitation since 2010
• 95% referrals now coming from general practice
• Followed by community exercise programmes
A Case Study
Mrs S

• Mrs S, 61 years old, lives with husband in temporary accommodation.
• Severe Chronic Obstructive Pulmonary Disease (COPD)
• Anxiety and panic attacks.
• Frequent admissions to hospital – six in six months.
The Issues

• No permanent housing post-earthquake
• Frequent panic-attacks related to dyspnoea resulting in ambulance call-out and admission to hospital.
• Intermittently relapsing into smoking
The Response

Person-centred Collaborative Care

• Flinders Care Plan – in partnership, identifies key issues and goals for self-management.

• Pulmonary Rehabilitation Programme – skills for self-management, improved exercise tolerance.

• Home visit from Community Respiratory Nurse and Physiotherapist – ‘real world’ care plan.
Collaborative Care

- Community & Social
- Secondary Care
- Primary Care
Outcomes

- Mrs S is following her Care Plan and feels more in control of her anxiety – no recent panic attacks.
- Currently not smoking and husband is also trying to quit.
- Remains in unsuitable temporary housing, placed in top priority category with HNZ.
- One overnight admission to hospital in last 3 months.
- Next Steps:
  - Support general practice to develop shared Acute Plan.
  - Liaise with ambulance to identify strategies for Mrs S.
  - Ongoing advocacy with housing organisations (Govt. and NGO) until resolved.
Ongoing Service Challenges

• Patient behaviour/anxiety
• Clinician behaviour – ED and on the ward(s)
• Linking across the system, e.g., ambulance accessing data
• Co-morbidities – bringing all the disease state activity together
• Social/welfare issues
Summary

• Define and share the vision
• Commitment to the agreed path
• Agree the quality framework including training
• Governance; stakeholder engagement including the funder(s)
• Consumer input every step
• Data to prove it’s working
• ‘Best for patient, best for system’ focus
www.ccn.health.nz

Thank you