Integrated Care

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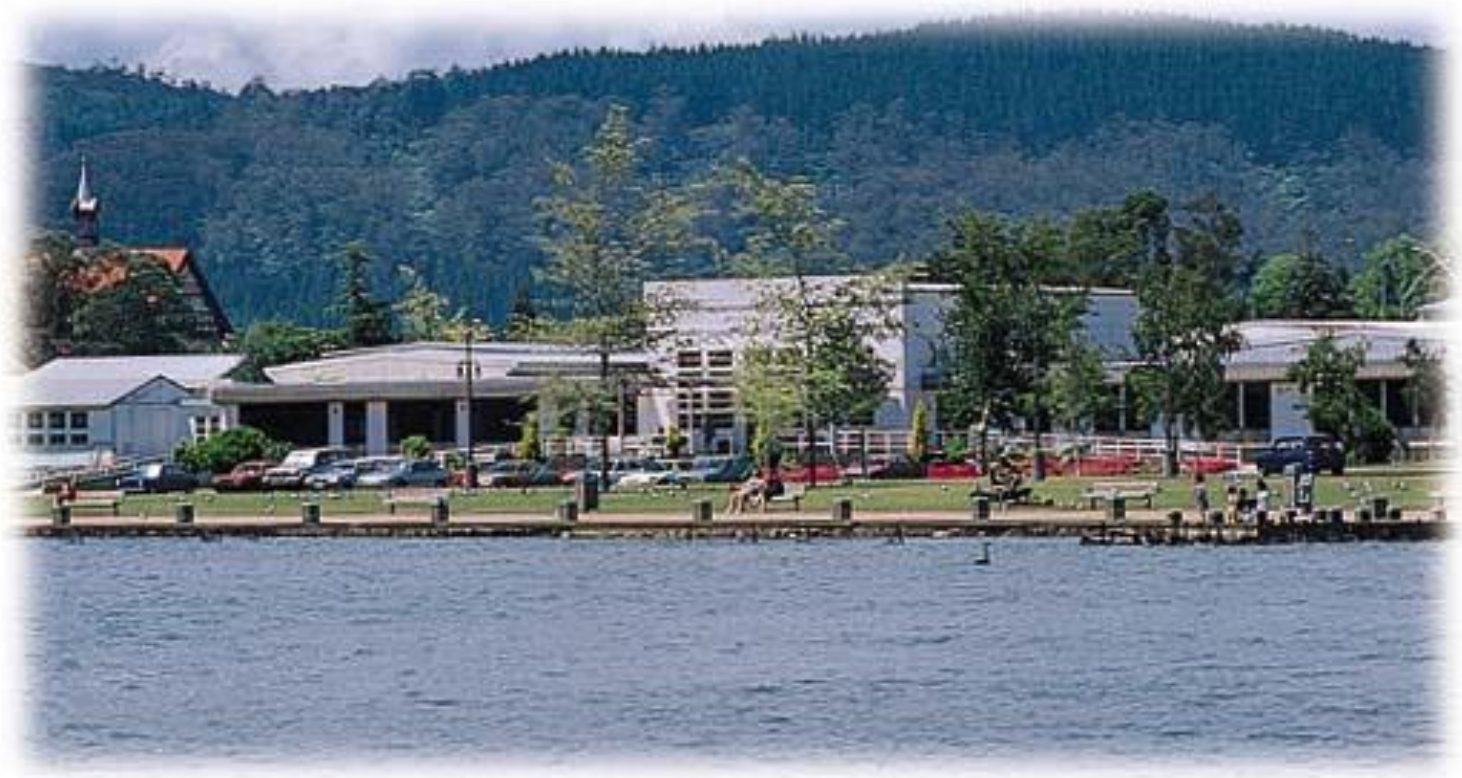
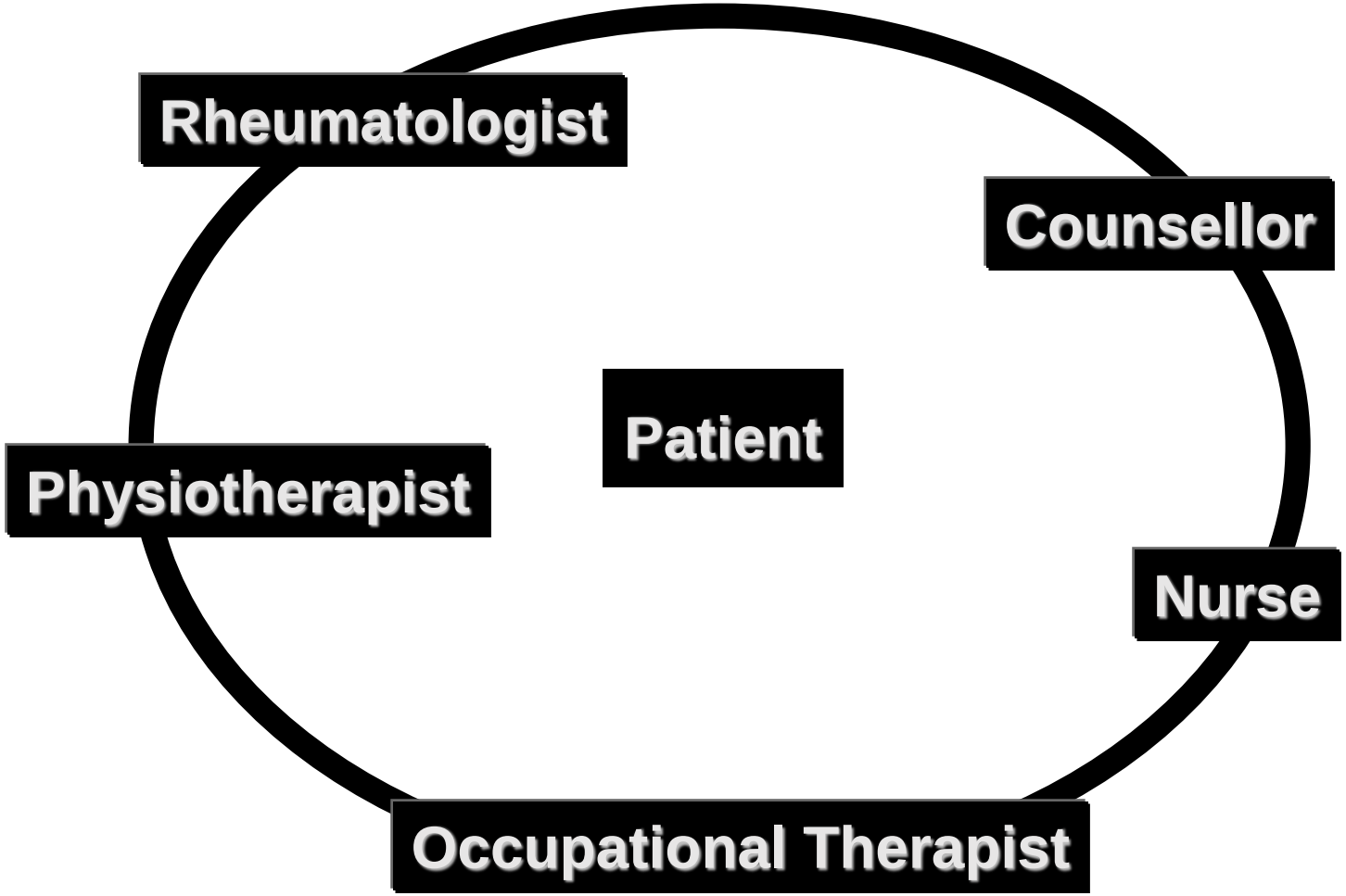
Levels of Integration

- Clinical integration – coordination of person-focussed care in a single process across time, place and discipline
- Professional integration – inter-professional partnerships both within and between organisations to deliver a comprehensive continuum of care to a defined population
- System integration – inter-organisation integration to deliver comprehensive services to a defined population

Rotorua New Zealand
QE Health 1995



MULTIDISCIPLINARY TEAM



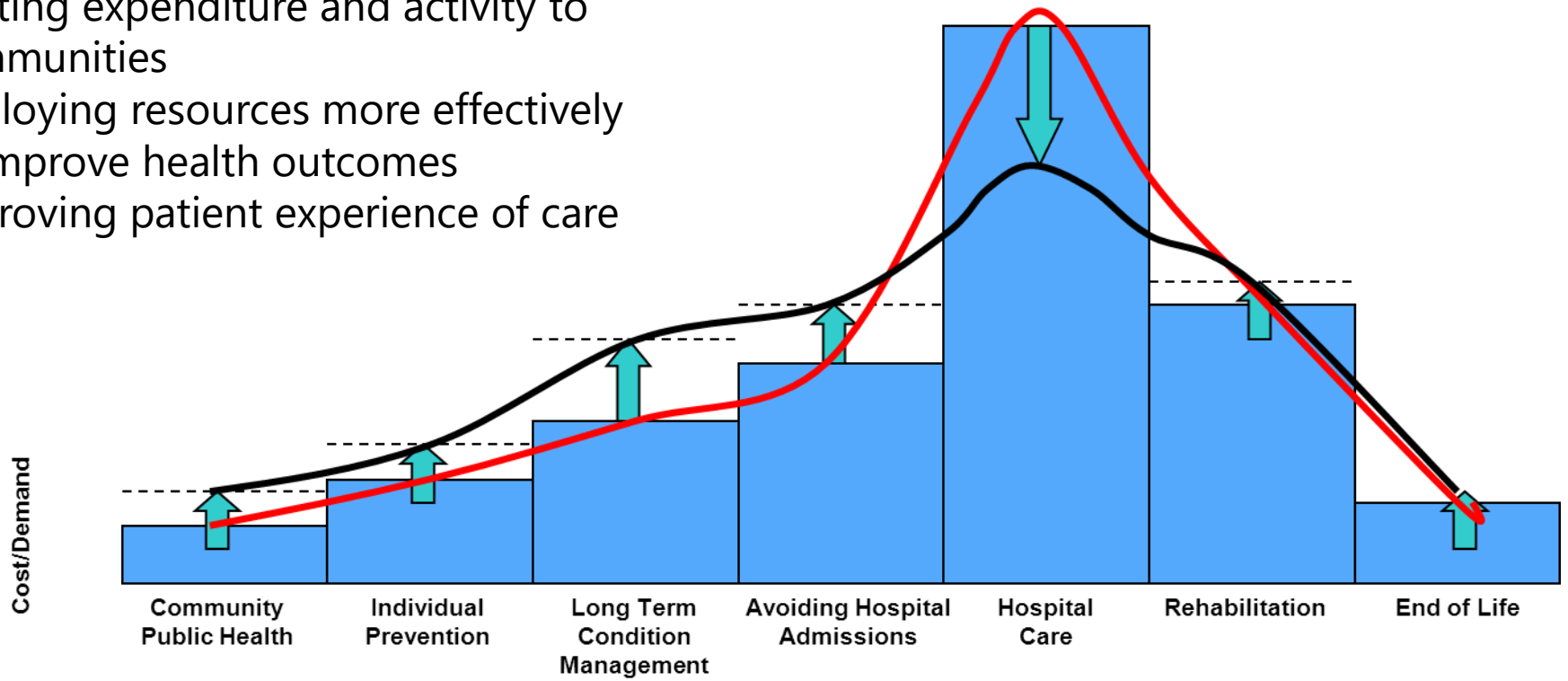
A Community Model for Rheumatology

- PHO based, DHB funded
  - Population 150,000
  - 500 FSA pa
  - 1200 Follow up pa
- Specialist 0.5FTE
- Specialty Nurse
- GPs with Special Interest

- GP referral
- Specialist supervision
  - 2-3 GPs plus nurse
  - Specialist-only clinics
- High use of virtual reviews and FSAs

Changing Models of Care

- Shifting expenditure and activity to communities
- Deploying resources more effectively to improve health outcomes
- Improving patient experience of care



Ref: Dr Helen Bevan, NHS Institute

Community Rheumatology

Advantages

- Maximises use of limited clinical resource
- Improves communication and relationships between primary and secondary health care
- Empowers primary health care by building capability to provide musculoskeletal health services
- Potential to develop new model of care that is better integrated and patient responsive

Risks/Problems

- It's still a secondary care model
- Limited capacity for primary care to support the model
- Poor access for hospital clinicians to rheumatology - inreach
- Management expectation that community based care should be cheaper
- Limited capacity for service development to meet expectations
- Sustainability

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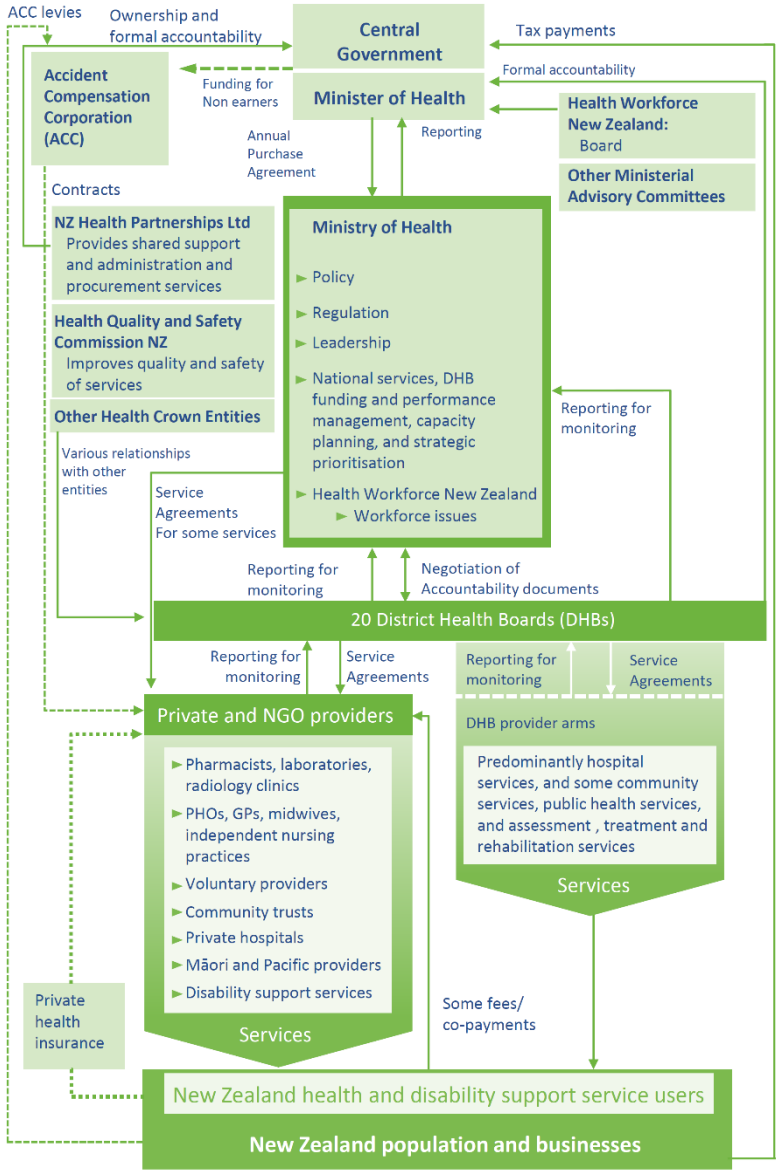
Improving Health Care

•*"To improve health care we require not better professions, but better systems of work. A "system" in this sense is a set of elements interacting to achieve a shared aim. Here is the trick: to improve the performance of the system you need to attend more to the inter-actions than to the elements. Great health professionals inter-acting well with all of the other elements of the healthcare system make great health care."*

•Don Berwick, "Medical Associations: Guilds or Leaders? BMJ, Vol 314, 564-1565

The NZ Health and Disability System



System Level Measures (SLM) Framework

A framework that supports the health system to improve health outcomes for people through focus on continuous quality improvement and collaboration

Key purpose of programme - all parts of the health system to work together using high level quality improvement measures

System Level Measures since July 2016:

1. Ambulatory Sensitive Hospitalisations (ASH) for 0-4 year olds
2. Acute hospital bed days
3. Amenable mortality rates
4. Patient experience of care
5. Babies living in smokefree homes
6. Youth access to & utilisation of youth appropriate health services

Philosophy of SLM Programme

- Provide an organising framework for continuous quality improvement
- Support DHBs to work with their local health partners, using an alliancing approach, to improve health outcomes
- Provide a stimulus to integration of services and systems so people experience integrated health care
- Focus on health outcomes by supporting improvement actions at the local level and reduce health inequities for Māori and other high priority populations
- Build capacity and capability for improvement and use of data to better understand local population needs and target investment
- Better use of resources - Best for the health care user and best for the system (people and process focus)
- Move away from pay-for-performance to harnessing intrinsic motivation to deliver patient centred care

The concept

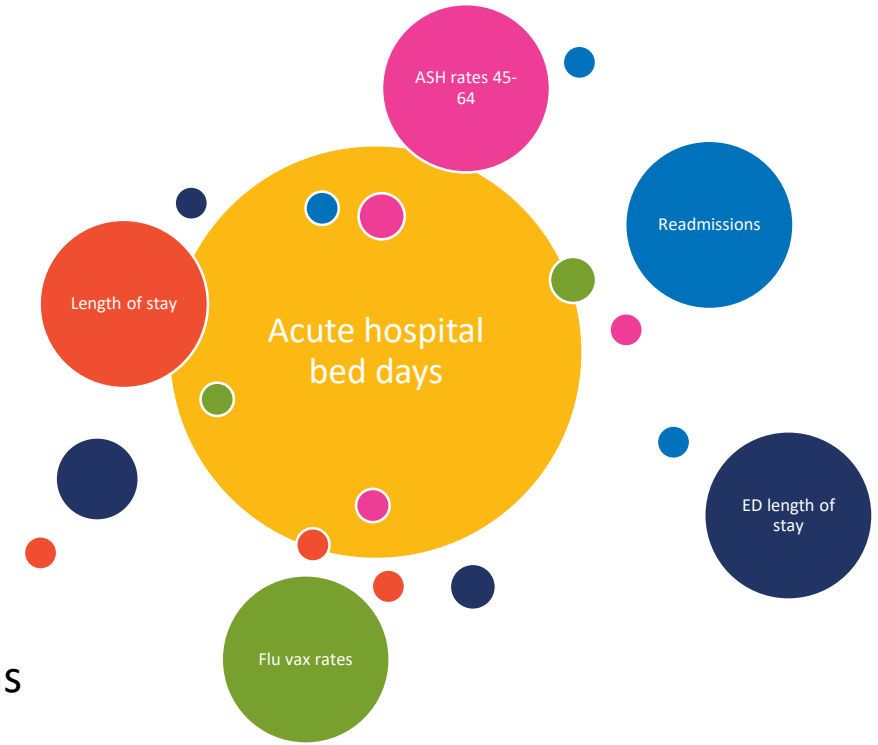
SLMs (big dots):

- co-produced with clinical, managerial and analytical expertise across the health sector
- focus on children, youth, Māori and high priority populations
- connect to local clinically led quality improvement activities

Contributory measures (little dots):

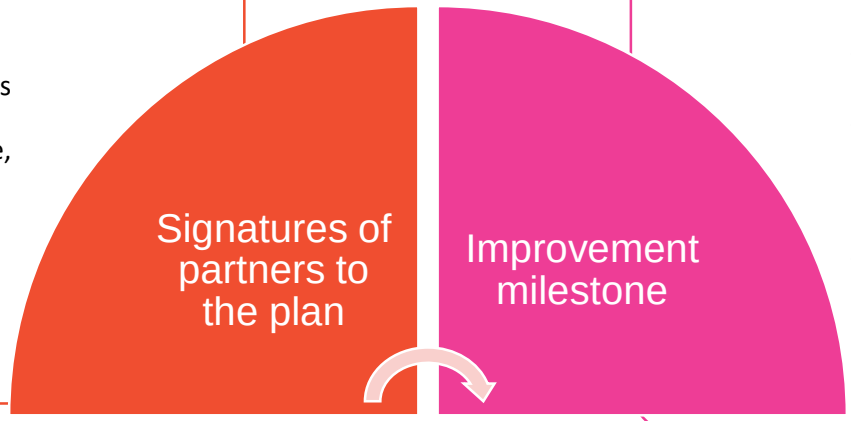
- Process and activity measures used to measure local progress against quality improvement activities
- chosen locally based on local needs, demographics and service configurations

Measures available online (www.hqmnz.org.nz)



Components of Improvement Plans

- integrated and partnership approach for the development of the plan
- includes all health system partners in the district eg patients/communities, ambulance, WCTO, LMCs, YOSS, pharmacy



- based on the district's trend and baseline data
- a number that improves performance from baseline
- addressing inequalities for Māori, Pacific and other population groups with significant health disparities
- determined through the use of health information tools and improvement science methods

- based on available and reliable data
- measurable with defined numerator and denominator
- chosen from the Measures Library
- have a clear line of sight to the improvement milestone and quality improvement activities

- action focused and achievable in one year
- contribute to the achievement of the improvement milestone
- reflect the integrated approach across the health system
- reflect the health investment needed based on local population needs, demographics and service configurations
- selected based on health information tools and improvement science methods

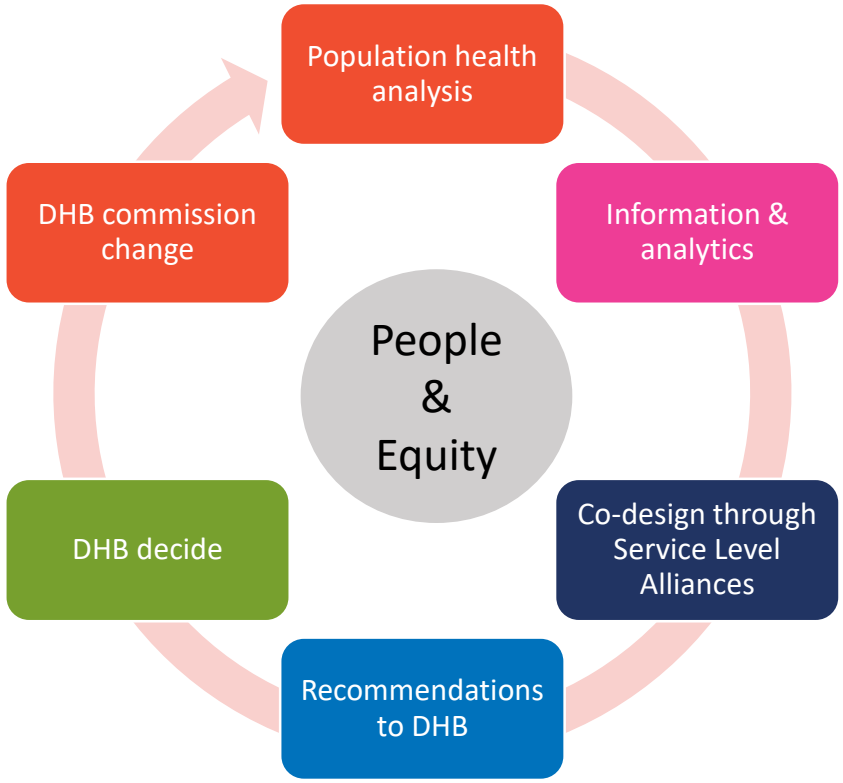
District Alliances

- Responsible for implementing SLMs in their districts
- Alliance between DHB of domicile and health service providers in that district
- Contractual requirement for DHBs and PHOs to form alliances
- Form, function and maturity varies

Role of district alliances:

- Harness perspectives from all component parts of health system to identify shared vision and key objectives for their districts
- Have a clear focus on delivery of integrated care by placing their population and patient at the centre at all times
- Lead the development of the SLM improvement plan
- Allocate resources required for the development, implementation, monitoring and reporting of the SLMs in their districts.

Continuous Alliancing Process



Example from Hawkes Bay SLM Improvement Plan

SYSTEM LEVEL MEASURE

Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.

However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socio-economic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via, e.g. healthy housing projects and parental smoking cessation programmes, may be considerable. Note that actions around access to primary care are included under SLMs - Using Health Resources Effectively and Prevention and Early Detection.

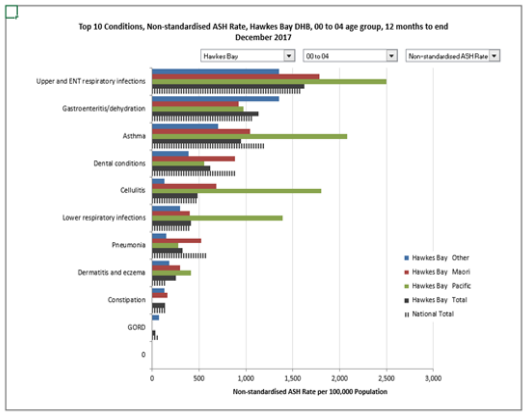
There is an inequity in the ASH rates 0-4 for Māori, Pasifika and other. The largest inequities are observed in cellulitis, dental and upper and ENT respiratory conditions.

The top ASH conditions for Māori are respiratory infections - upper and ENT, asthma, gastroenteritis / dehydration and dental conditions.

	Baseline*	2018/19 Milestone
Total	6,000	Māori 6,320 (20% reduction in gap, 5 year elimination
Māori	6,693	
Pasifika	10,000	
Other	4,824	

*12 months to December 2017

SI 1: Ambulatory Sensitive Hospitalisations (ASH)



CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Decreased hospitalisations due to dental conditions for Māori & Pasifika 0-4 (rate per 100,000)	Māori: 882 Pasifika: 556 Other: 390	Māori: ≤ 784 Pac ≤ 523 20% reduction in equity gap)
Decreased hospitalisations due to respiratory for Māori and Pasifika 0-4 (rate per 100,000)	Māori 3,625 Pasifika 4,931 Other 2,518	Māori ≤ 3,404 Pac ≤ 4449 (20% reduction in equity gap)
Decreased hospitalisations due to cellulitis for Māori and Pasifika 0-4	Māori 681 Pasifika1806 Other 130	Māori ≤ 543 Pac ≤ 1472 (20% reduction in equity gap)

HOW WILL WE ACHIEVE IT?

- Develop a standardised respiratory pathway to follow up tamariki in primary care post admission.
- Develop a paediatric respiratory programme that supports tamariki and their whānau from secondary to primary care.
- Provide increased community based respiratory support for tamariki and their whānau during peak winter months.
- Develop a pathway for community oral health service referrals to secondary care to ensure the child's appropriate primary care practitioner is informed of the child's health status.
- Pilot General Practice 'Lift the Lip' at 15-month immunisation visit.
- Work with the Child Health Team to distribute the skin care resource to early childhood centres, Kohanga Reo and Punanga Reo/language nests, taking a population health approach to promotion and socialisation of the resource.

Ministry's role

Ministry, as stewards of the health system are responsible for:

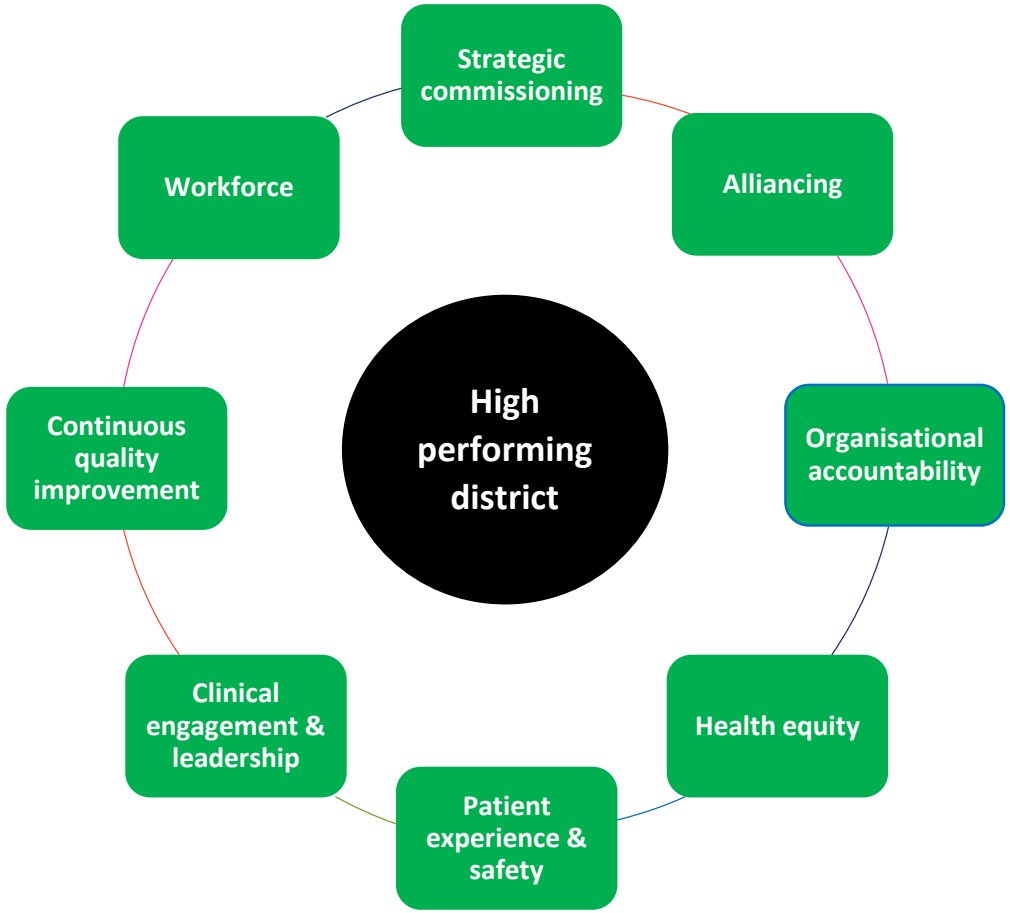
- Providing strategic direction for the health system improvement informed by health sector clinicians
- Creating an environment for collaboration between different parts of the health system
- Providing accountability for health system improvement through approving and monitoring progress of the annual SLM improvement plans
- Curating an online measures library to increase visibility of defined and reported measures from frameworks across the system
- Build health system capacity and capability for quality improvement by:
    - Facilitating sharing of identifiable data from the national collections. This engages frontline healthcare professionals in quality improvement.
    - Supporting the Health Quality & Safety Commission with local level quality improvement initiatives.
    - Working with the Health Quality & Safety Commission to implement the national primary care and hospital patient experience surveys.


Frontline health professionals engaged and leading local quality improvement
Gave alliances a purpose
Broadening of alliances
DHBs and PHOs working together to improve the health of their populations
Three metro-Auckland DHBs seven PHOs combined to produce single plan
Patient ID data made available from national collections
Improvement of data integrity
New measure for youth health
Provided a framework for addressing equity
Results of SLM programme

Observations three years on:

- Sole focus of the system on accountability (financial and performance measures)
- Conversations provider and profession - focussed
- Lack of focus on relationships, interactions and behaviours
- Variable improvement capacity and capability in DHBs, Ministry and broader health sector
- Variability in district alliance maturity and functionality
- Variable clinical leadership and engagement
- Variable patient and community engagement
- Lack of investment in broader primary health care
- Challenge in sustaining relationships, clinical engagement and bringing new partners into alliance

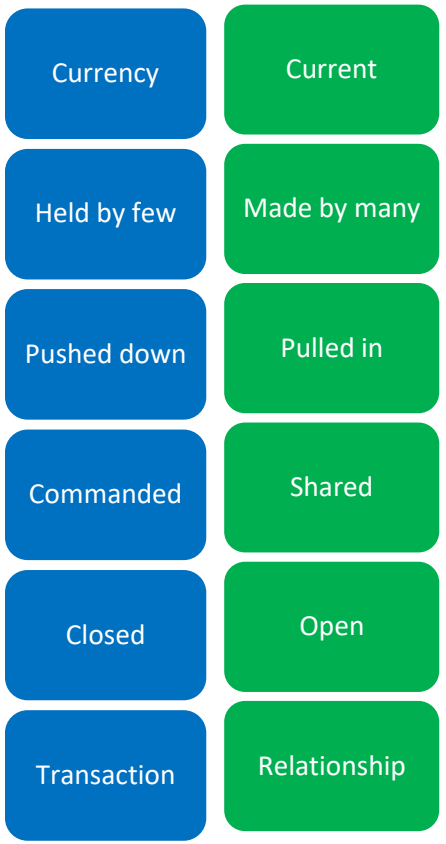
Dimensions of System Integration Framework



Recognising the strength of 'new power'

Old Power (Health targets)

- Performance management
- Accountability
- Targets
- Sanctions
- Leader-driven
- About economic resources ($$, materials, technology which diminish over time)
- Important part of the system but not the whole



New Power (SLMs)

- Uses intrinsic motivation (values)
- Participation and peer-coordination
- Do it yourself
- Informal networks (alliancing, collaboration, community)
- Building capacity and capability
- About social resources that grow with use
- Co-producing and sharing
- Transparent

*Heimans, J. and H. Timms (2014). "Understanding "New Power" The crowd is challenging traditional leadership. Here's how to harness energy." Harvard Business Review **92**(12): 48-56.*

Summary

- Integrated care has different meanings and levels
- Putting patients at the centre of care requires an integrated health system with shared common purpose
- Health system integration requires transformational change
  - Models of care
  - Structures for engagement
  - Commissioning/funding

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