



Is there a gap ?

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Our community



Background

- Admission rates to EC continue to rise
- Frequent Adult Medical Admission Report
- CCM Programme uptake for some modules is inadequate and we are not effective for improving the health of clients for Frequent Adult Medical Admissions therefore we are not reducing avoidable hospital admissions.

Proposal

“That two PHC nurse specialists work collaboratively with the general practice team and a senior secondary consultant to case manage clients over a four month period”

Utilising the skills of NASC, CHW, Social Workers, Cultural team, Pharmacist etc etc...

Objectives

- Appropriate community based case management
- Advocate entitlement to the CCM programme
- Facilitate clients access into the CCM programme
 - ↑ improve care
 - ↓ reduce avoidable admissions
- Build nursing capacity in general practice
- Participatory action research

Approach and methodology

Access to CCM project: 22 May 2007 – 30 September 2007

- Develop and strengthen relationships with key stakeholders
- Consult with ACT team in EC – identify eligible clients admitted from two large General Practices
- Collaborate to clarify clients eligible to access
- Facilitate case conferences
- Assist practice nurses develop new skills and competencies
- Evaluate the processes surrounding access into programme, client outcomes (health/social), client satisfaction, general practice satisfaction, organisational outcomes, including learning with the professions

Demographics

	Practice One	Practice Two
Number of GP's	6.6 FTE's	6
Number of RN's	8	7
Number of enrolled patients	9000	12337
Named CCM nurse	1	Every RN
CCM modules offered	all	all As at 12/10/2007



Inclusions

- Adult clients enrolled with the two selected practices who meet the FAMA criteria
- Nominated by PN or the GP team or
- Identified from the EC database
- Heart 'synch' or Heart 'sink'

Key performance indicators

- Enrollment – active participation in CCM
- Entitlement to health and social services
- Improved health status
- Reduction in presentations to EC
- Reduction in length of stay
- Provision of pharmacy review
- Shared learning – professional development
- Client satisfaction
- Provider satisfaction

"I'm expecting Baycorp to knock on the door....."

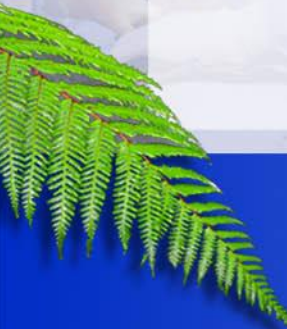
Case study Mr P

Problems:

Obstructive airways disease:

- Asthma ? Work related
- Smoking related chronic airways disease
- Current smoker with 45pk/yr/hx
- Previous ICU admission (2005)

....so why would you not go to EC?.....



Mr P

- Heart synch - general practice asked for input.
- Seen at surgery by Prof Rea, CCM nurse and PHCN
- Patient stopped Serevent - gives him a sore throat
- Highly atopic with sensitivities to house dust-mites and pollens
- Changed to Symbicort turbuhaler
- Claratyne 1 tablet nocte
- Anger – see Health Psychologist

...receives \$15.00 a week...

Who did what

- General Practitioner: PATHS, C.S.W.,
- Practice Nurse: check inhaler technique, spirometry, Epipen, smoking cessation
- Secondary consultant: skin prick allergy tests, CT scan, bronchoscopy
- PHC nurse specialist: Health psychologist, smoking cessation, nebuliser, mattress, pillow covers

Where to from here?

- Mr P has taken letters to case manager – approval for nebuliser gained
- Mr P has approached Workforce in regard to work
- Re increase in hospital presentations....
 - Does he need a case manager?
 - A community matron?
 - Or a navigator.....?

....empower the client to set goals....

Case study Ms V

Diagnosis description

- Diabetes, CHF, renal impairment, morbid obesity, hypertension
- ?OSA never investigated
- 5 admissions in past 12 months
- 13 bed days utilised
- non compliance with medications

Ms V

- General practice review
- Discussed at surgery by Prof Rea, practice team and PHCNS.
- Arrange a home visit with CHW
- Home visit

Who did what

- General Practitioner: Liason, consultation role
- Practice Nurse: Arranged blister packaging, two way learning
- Secondary consultant: Arranged sleep studies, echo and spirometry
- PHC nurse specialist: Contacts with special needs education, WINZ, HNZ, local pharmacy

Learnings...to bridge the gap

- Relationship building
- Improved access between GP to consultants
- Practice nurse to PCNS
- Engagement in their environment
- Social justice – reducing inequalities
- Step slowlywalk alongside....understand their reality

“Together we can make a difference”

To complete the bridge...

- Project completed September 30
- Ethics approved granted
- Project written up by Jan 2008
- Recommendations
 - ? Virtual clinics
 - ? Geographic alignment
 - ? Community 'matrons'
 - ? Need to duplication in other areas ?