International Journal of Integrated Care

Scott, T et al 2020 Community Health of Older People Initiative; An integrated, timely and collaborative care approach for prefrail and frail older people living in the community. *International Journal of Integrated Care*, 20(S1): A188, pp. 1-8, DOI: doi.org/10.5334/ijic.s4188

POSTER ABSTRACT

Community Health of Older People Initiative; An integrated, timely and collaborative care approach for prefrail and frail older people living in the community

2nd Asia Pacific Conference on Integrated Care, Melbourne, 11-13 November 2019

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Background: Primary care in Wellington, New Zealand recently expressed a need for more timely, flexible responsiveness from the secondary care service for frail or complex older people. Currently wait-time for a geriatrician review is two months; there is limited nurse practitioner resource. There is a national and local imperative for increased integration between primary and secondary services, supported inter alia by the Health Care Home model.

Aim: This initiative aims to provide a more timely, flexible and collaborative service to primary care in order to help older people remain healthier and living in their own homes through a person-centered and integrated model, enriching the scope of primary care, responding quickly to the acute frail person, and promoting proactive approaches to optimise the functional trajectory of older people; additionally enriching scope and integration within secondary care and avoiding silo effects.

Methods: The initiative will commence in August 2019 in Capital & Coast District Health Board (CCDHB). A related project places 1 FTE clinical pharmacy facilitator across two GP practices. The staff comprise 0.5FTE Geriatrician and 2 full time Nurse Practitioners embedded in an existing Multidisciplinary Older Adults and Rehabilitation (ORA) team. The initiative will start in 2 Health Care Networks (geographical GP practice clusters). Nurse Practitioners will provide same day in-home response to urgent referrals. They will also see people with complex geriatric issues. The Geriatrician will support this work. She will offer case-consultation to primary care at their practices, by phone and by telehealth. Attention to proactive care planning will be promoted, especially falls, polypharmacy, and advanced care planning. The LifeCurve concept will be socialised to practitioners and people and their families. The Ministry of Health has prioritised achieving equitable health outcomes for Maori. Ways of care provision that work for the people will be explored; and for other populations e.g. Pasifika. All 3 staff will form and encourage strong linkages, case-consulting and peer support among primary, secondary and NGO services.

Quality framework and appraisal plan: The project is sponsored by the CCDHB Strategy Innovation and Planning service, and follows the IHI Method for Improvement quality framework. There are several clinical practice innovations plus exploration of processes already embedded in the organisation, including referral, triage, IT communication, statistics gathering and outcome measures. Workshopped driver diagrams have informed the initial clinical approaches; process mapping has clarified opportunities for process improvements. PDSA cycles will inform early adaptations once service delivery begins. Outcome measures will be structural, system

performance, system impact and person impact. LifeCurve status will be captured to inform service development. Patient Reported Measures are under development; they are novel for CCDHB. A formal appraisal will be conducted after 12 months and will include a qualitative study of impact on primary care clinicians, people and families. It is anticipated that if the initiative meets its aims, the model will be rolled out across the whole catchment. Additionally there will be ongoing scrutiny of successes and lessons learned to inform current and future integrated care projects within the organisation.