
CONFERENCE ABSTRACT

Towards Integration: Dispatches from the Front Line

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Introduction: The arguments for Integrated Care are compelling but implementation is challenging. In New Zealand care between general practices and hospitals is fragmented and achieving integration between these institutions made more difficult because of varying ownership, funding and governance arrangements.

We are testing a model to help overcome these barriers by integrating care at the level of the individual patient, rather than between institutions.

A General Practice based Transitional Care Nurse: Ranolf Medical Centre is an urban general practice serving about 11,500 patients. We recently appointed a Transitional Care Nurse (TCN) to co-ordinate care for our patients admitted to Rotorua Hospital. The TCN visits patients in hospital, helps share information between hospital and practice, informs the practice about progress, helps with discharge planning and visits patients in their homes on discharge. She works with hospital and community pharmacy to improve medicines management. In the home she helps with health literacy, follow up arrangements and with planning early intervention in case of illness relapse.

The aim of this initiative is to test whether a nurse 'walking alongside' the patient, between home, practice and hospital - the transitions of care - may improve patient experience and outcomes, improve health literacy and self management and reduce ambulatory sensitive admissions.

Whilst there are a number of transitional care nurse roles already in practice they tend to be involved with a particular discipline, eg cancer care or paediatrics. We are testing the role for any patient registered with our general practice, based on a patient centred assessment of need, for any individual rather than one limited by disease or discipline.

Evaluation: This is a two year 'proof of concept' initiative, funded by the Ministry of Health and Lakes DHB. Evaluation is supervised by Prof Tony Dowell of the University of Otago and will comprise quantitative data on admission and ambulatory sensitive admission rates, as well as qualitative measures of patient and clinician/team experience and patient vignettes.

Initial experiences: We began in earnest in February 2016. Initial experiences are encouraging. Patient feedback in particular is very positive and we have already documented compelling patient vignettes, (including avoided harm). Of particular benefit has been the development of an issues register of the myriad challenges (small and large, anticipated and unanticipated!). We are creating solutions for things we had no idea would be problems.

This presentation will outline our experiences of the first nine months of this initiative.

Conclusion: To borrow from Donald Schon: the view from the mountain top is crystal clear - integrated care offers many benefits and is an important policy direction for our health system. However, in the swampy low lands of day to day practice change of the magnitude required will be challenging. The new role of a Transitional Care Nurse may be a useful agent to help achieve integration.

Keywords: transitional care nurse; general practice
