

POSTER ABSTRACT

Navigation & Case Management Supporting General Practices in the Eastern Bay of Plenty, New Zealand

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The findings from a 5-year navigation and case management service supporting General Practice in the Eastern Bay of Plenty, New Zealand.

Introduction: The Eastern Bay of Plenty has 12 General Practices and serves a population of 48,000 with 64% classified as having high health needs. In 2014 the Eastern Bay Primary Health Alliance EBPHA launched a new service to embody a collaborative approach to healthcare and partnered with General Practices to support patients with their health, understanding and management of their chronic conditions and / or complex needs.

The rapid ageing of the population has produced a mismatch between health problems and health care with chronic conditions on the rise. A paradigm shift was required to advance the efforts to solve the problem of managing diverse patient demands given limited resources.

This new delivery model highlighted 'improved integration' and 'ensuring that every dollar invested in the ICM service saves several within the wider system' as key drivers.

Project description: Requiring the support from all 12 General Practices in the Eastern Bay and the establishment of two regional multi-disciplinary teams; the project was launched in 2015. In engaging with stakeholders, we emphasised the requirement to improve the standard of referrals and introduced the Health Planning Tool HPT. This has been a key differentiator in the development of the Integrated Case Management service as it ensures that the information provided by General Practice improves the case planning process and increases multi-disciplinary input.

General Practice now have greater involvement in the care planning process with provision being made in 2015 for a subsidised consultation to assist in agreeing to the clinical care objectives and treatment strategies.

One of the greatest challenges is demonstrating the impact on hospital activity and the subsequent impact on cost savings. A new 'E3' Evaluation Tool was developed which provides wrap around feedback from patients, case workers and the referring community to determine if the ICM intervention is positively affecting these outcomes.

A second subsidised consultation was introduced in 2017 to support the premise that General Practice is the 'medical home' for patients in the Primary Care setting and the E3 is a critical tool in validating our approach by using evidence based feedback.

Results: Referral numbers from General Practice have increased by 350% over the 3-year period with both regional services having to adapt operationally to accommodate the increased demand.

A redesigned model of care that integrates and coordinates existing services and minimises duplication.

A Health Planning Tool HPT which provides real time visibility of a patient's care journey.

The development of the methodology E3, which tells us that the Integrated Case Management ICM Service improves patient outcomes, reduces hospital admissions, minimises duplication and saves money.

Keywords: health planning tool; multi-disciplinary; e3 evaluation tool; redesigned model of care; managing diverse patient demands
