Connecting Care through partnership

The Very High Intensity Users (VHIU) service was developed to address needs of patients with complex co-morbidities who frequently present to emergency care (EC) at Middlemore Hospital in South Auckland, New Zealand.

From working initially as a hospital-based team, the team now works in partnership with General Practice Teams.

Together we identify barriers for each patient, develop and implement tailor-made and individualised solutions to enhance primary care engagement and person-centred care.

This has resulted in a 33% reduction in the use of acute care services due to incidence of multiple comorbidities.

A core aspect of the VHIU service is to bridge silos, where patients commonly get lost, or systems fail the patient or their families/whānau.

Background

In the year ending February 2010, the following patients presented to Middlemore hospital:

- 64,409 patients presented to EC 88,565 times.
- 1711 were VHIU and had 8756 presentations

Total cost of VHIU patients: $31.5 million

Counties Manukau Health Demographics

- Estimated population 512,130 (2013)
- Ethnicity profile: 23% Pacific, 16% Maori, 22% Asian
- Over 65 population is expected to double to 90,170 by 2026.
- This population group places the highest demand on services due to incidence of multiple comorbidities
- 38% of the population of Counties Manukau Health live in socioeconomic deprivation²
- 13% of the adult population live with CVD and/or diabetes

Problems

- Lack of continuity, disjointed and siloed of care
- Reactive episodic care
- Patch protection between services
- Repeated assessments not shared between health providers
- In-effective communication systems
- Dis-engaged patient and families
- Poor access to primary care (transport, funding)
- Health beliefs that only hospitals provide care

Barriers to accessing healthcare

<table>
<thead>
<tr>
<th>Housing</th>
<th>Care at Home</th>
<th>Poor Health</th>
<th>Living with a dependent</th>
<th>Low income</th>
<th>Low education</th>
<th>No support services</th>
<th>$ Earns a health barrier</th>
<th>Poor compliance meds</th>
<th>Not Māori</th>
</tr>
</thead>
<tbody>
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VHIU Case Study

The VHIU link team were asked to become involved with this 56-year old female whom the hospital Consultant had serious concerns about. She had repeatedly presented to hospital due to life-threatening low calcium levels. The women had multiple co-morbidities.

VHIU Link Team members (pharmacist and social worker) visited the woman at home following another presentation to hospital. The dominat catalyst for presenting to EC was found to be the woman’s challenge to keep up with multiple tablets and different dose times. This included confusion over two similarly packaged medications which impacted on her calcium levels:

VHIU Link Team established a more informed, comprehensive and convenient routine of medication management. A medication organiser was provided to enable her to monitor her daily compliance and also a chart which provided explanations relating to her medicines. The outcome included a clear understanding for the woman of managing her health through improved medication use and also for her primary health team.

VHIU model

Following successful establishment of the VHIU model of care which involved improved communication and co-ordination with Primary Care providers for patients with complex needs.

A strong focus included empowering patients to manage their health needs, understand their barriers and help navigate through services.

Key prompts include:
- What concerns you most?
- What is important to you?
- What stops you from …?

VHIU Connected Care model

VHIU extended and expanded their involvement with Primary Care Providers in the care of the complex patient. This includes co-ordinated care approach jointly shared with the VHIU and Primary Care Team.

Key partnerships include: partnering VHIU team and Primary Care practice teams and also multi-disciplinary teams, and connecting patients with health care providers and services.

This is achieved through, for example:
- Joint home visits
- Collaborative case management
- Primary health and Interdisciplinary case review meetings
- Compatible IT computer systems

VHIU Social Worker with Nurse and patient in her own home

VHIU Nurse and Practice nurse discuss care plan and collaborate on follow up

References:

2. NZ Index of Deprivation Atlas, Ministry of Health 2013

Simple and successful strategies included:

- Identification of specific clinician skillset, experience and knowledge, and commitment to improving patient care
- Funding to create traction and encourage culture change
- Partnering with pilot general practice teams until processes established
- Case review management undertaken in GP practice
- Management and stakeholder support to facilitate time away from traditional roles and responsibilities
- IT systems compatible for shared care planning and communication

Sponsorship and funding:

The VHIU collaborative team are: Clinical Leads: Prof Harry Rea Team Leader: Ta Mera Rolland Campaign Support: Alison Howitt Acknowledgements: VHIU and General Practice Teams