South Taranaki

Alive with opportunities for better health care

project

A GP response May 2011

Views contained in this Powerpoint are not necessarily the views of the Taranaki District Health Board. Information that appears throughout this document has been compiled during discussion with South Taranaki GPs which Dr Keith Blayney presented on their behalf.

Health needs assessments

- Rapid Health Profile
- Clinical Forums including GPs
- Bishops Action Foundation Report
- South Taranaki Business Analysis

Rapid Health Profile

- 2006 Census 26,500 (**25.4%** of Taranaki) [26,600 in 2010 SNZ est]
- Higher deprivation, smoking, Maori, young, and birthrate
- Of the 30,180 Taranaki hosp discharges 7,690 came from ST = **25.4%, the same as our population proportion.** Of those 34.25% (2634) were discharged from HH. TBH discharged 23,366 (including 5,056 from ST). Assuming the same ratio of 34.25% not needing high level specialist input, we have (30,180-5056) x 34.25% = 7225. 2634/(7225+2634)x100 =**26.7%**
  So the expected discharge numbers for Hawera are only marginally higher than expected (26.7% c.f. 25.4%) probably reflecting greater Maori and higher deprivation.
- Crude attendance at Hawera ED =591/1,000 with far more in office hours than at Base ED.
- **In keeping with Midlands, 50% of ST patients attend small 1-2 doctor primary practices (i.e. not Ruanui or Southcare)**

TDHB Senior Management

“Current arrangements unaffordable because of a falling ST population and less money than other DHBs”.

- **However the population of South Taranaki is in fact rising [26,487 in 2006; 26,600 in 2010 - SNZ] while our birth rate is 14% higher than the rest of Taranaki.**

- **The latest Budget increases the TDHB funding from $275.45m to $282.86m, an increase of $7.41m GST excl. Hawera Hospital costs $10.8m p.a. (which is $9.4m without GST i.e. 3.3% of the TDHB budget)**

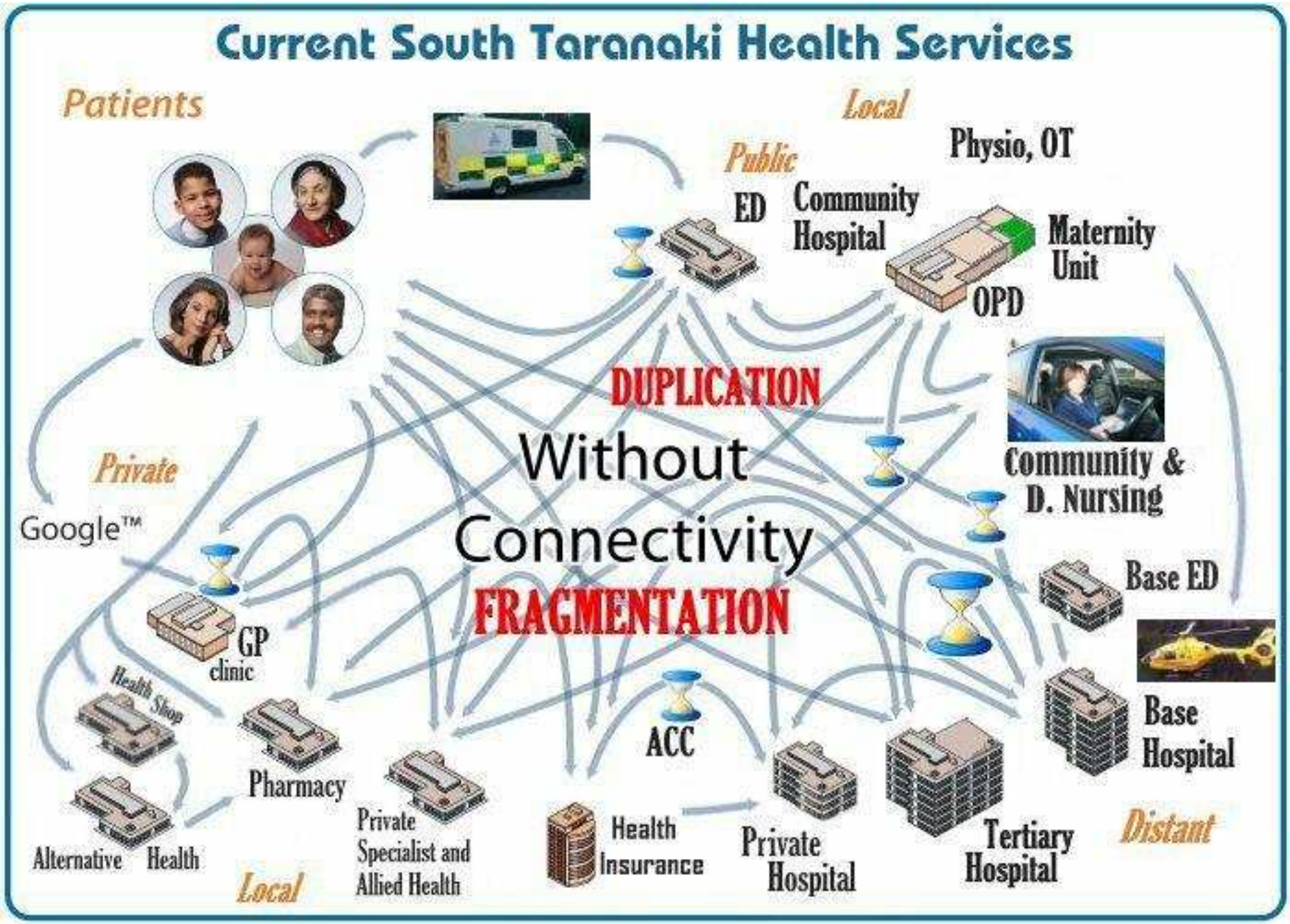
Government requirements

- Better, Sooner, More Convenient
- Primary health to better manage chronic conditions to reduce demand on hospitals
- More frontline clinical services and less management.
- The Minister of Health wants the TDHB to “engage with the South Taranaki community over changes to models of care as part of **possible** plans to reconfigure hospital services” [Hon Tony Ryall 8 Nov 2010 instructions to the TDHB over the DAP]

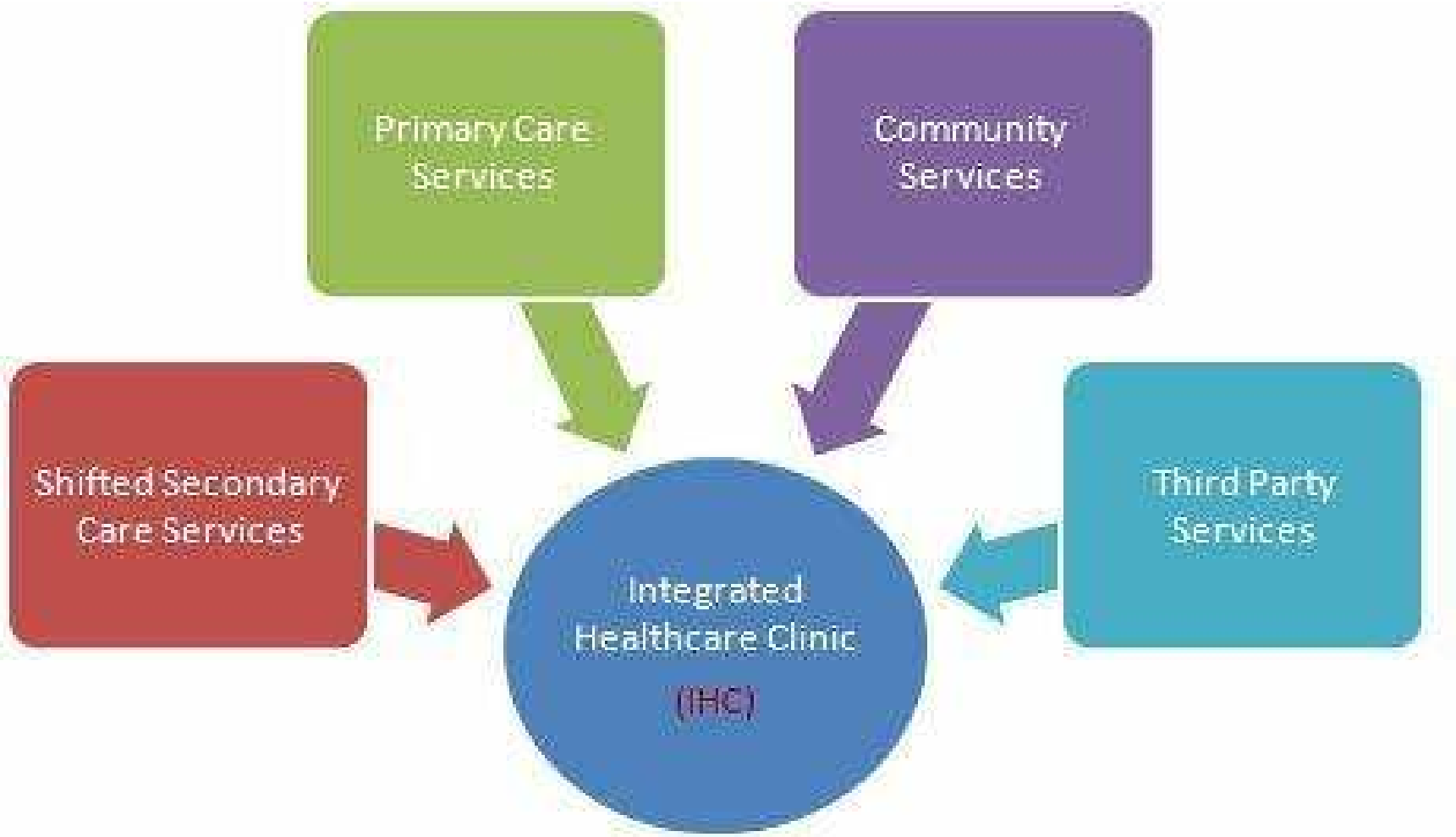
Collated Health Needs

- Better access to GPs [so need smarter use and better Retention & Recruitment]
- Better Access to specialist and ancillary health services
- Retention of Hawera Hospital –ED, OP, inpatient, Lab, Maty, DN
- All achieved with no increased cost to patient or Government!

Current South Taranaki Health Services



Integrated Health Care Model



Designing Future Pathways for Health

3 day “Gemba” Workshop

27-29 April 2011

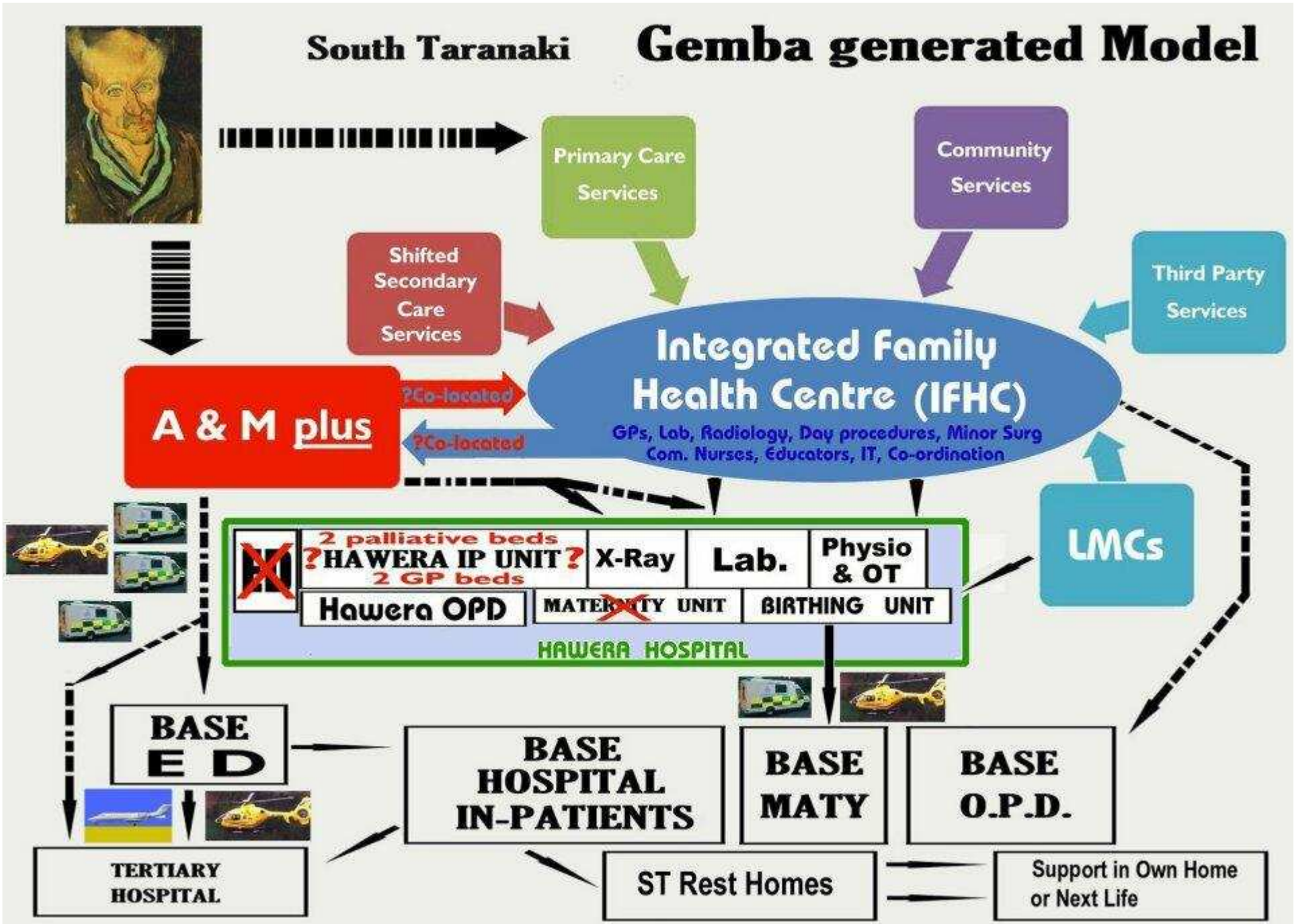
Future State – Day Two Gemba Workshop – 28 April 2011

Agreements

- Integrated Health
- Primary/Community led service
- Early intervention is a priority
- X Patient can access records
- The current system must change
- Reducing inequalities
- ? Siloing doesn't work in South Taranaki
- Care navigators/kaiawhina
- ?X Nurse led clinics
- ?X Shared booking system – Doctors, nurses, outpatients
- X? Single point of access/referral management
- Expand GP teams
- Time appropriate service
- We are all in this together
- Use of virtual medicine
- X ED acute care and GP care to combine
- Improved access to diagnostics
- Standardised clinical and referral pathways
- Primary prevention is a priority
- ? Ambulance resources are over qualified
- Ambulance staff can be better utilised during "down time"
- Patient/self responsibility
- Services to patients – not necessarily physical
- Transport partnerships
- X Single physical hub

Open issues

- Access to medicines
- Oral health
- Mental health
- What is the Hawera Hospital?
- Where does Base fit?
- Wanganui/Taranaki boundary
- Recruitment and retention and training
- Who does what? Doctors, nurse, Allied Health
- Who owns notes? Privacy advocacy GP
- Impact on registered nurses and community services
- Cost effective
- Expectations of ambulance service
- Disabilities
- Reducing inequalities
- Location of any beds
- Allocation of resources
- Impact on Maori/venerable
- Sickness/invalid benefit standard


South Taranaki
Gemba generated Model
Primary Care Services
Community Services
Shifted Secondary Care Services
Third Party Services
Integrated Family Health Centre (IFHC)
GPs, Lab, Radiology, Day procedures, Minor Surg
Com. Nurses, Educators, IT, Co-ordination
A & M plus
?Co-located
?Co-located
2 palliative beds
?HAWERA IP UNIT?
2 GP beds
X-Ray
Lab.
Physio & OT
Hawera OPD
MATERNITY UNIT
BIRTHING UNIT
HAWERA HOSPITAL
LMCs
BASE E D
BASE HOSPITAL IN-PATIENTS
BASE MATY
BASE O.P.D.
TERTIARY HOSPITAL
ST Rest Homes
Support in Own Home or Next Life

GP response 1

What GPs like……..

- Local integration of Community Health & OP services, transport etc

- More trips to TBH gives the “overqualified” ambos something to do as most cases won’t need a transfer nurse or doctor (but a HCA is not appropriate)
- …….
- …….

GP response 2

What GPs don't like……..

- **Physically placing a ST community health hub as an IFHC in a single practice** which already has **ACCESS** problems. 63% of the ST population attend other practices and do not wish to access services through S/C. Public funded services such as ETT (stress ECG) should not be moved into an IFHC without good cause and if they were, they should remain free to ALL ST patients without discrimination.

- **Downgrading the Maternity unit to a birthing unit.** This will be a disaster for LMC **retention** in ST for no advantage. It was not a recommendation of the workshop.

GP response 3

What we don't like……..

A&M instead of an ED.

- This is not wanted by any GP, including any AMPA qualified or Medical Officer.
- No GP or MO is prepared to staff an A&M clinic – GPs are already overworked and are not prepared to work additional hours, even if remunerated well.
- ED doctors and GPs are not interchangeable, there are clear differences in scopes and experience of practice
- There are issues for AMPA qualified/training doctors where A&M on-call is not counted for accreditation.
- If the ED closed, South Taranaki would lose Medical Officers and possibly some GPs.
- Dentists have stated that they are not prepared to work at the hospital without ED back-up and the MSS bus would have to restrict the type of surgery offered.
- The **need for After-hours GP services is not high** on the community's stated needs. If something is really urgent after-hours, it should be seen at ED. If it is not urgent, fix the day-time access problem, not make it worse by really over-working GPs.
- Current ED service costs $2.1m;
- A&M with 2 overnight beds, 2 nurses/paramedics and doc on call cost= $1.7m, not including the cost of more referrals to TBH ED.
- This is **counter to the stated needs of the community to retain the ED and Hawera Hospital**, all to save $400,000, but spend more on transport and at Base ED.

GP response 4

What we don't like……..

- Reducing In-patient beds to 2 palliative and 2 GP beds.
- GPs generally are not willing, able or qualified to take on GP beds
- Relocating Hawera beds to TBH is likely to cost more and create unnecessary dislocation for elderly, particularly Maori, with little proven benefit.
- Having 2 palliative, 2 "GP" plus ?2 day case and 2 ED beds will still require much of the support presently needed, so there will be little overall financial saving for the TDHB but **TOTAL** loss of faith from the ST community.
- Hawera Hospital staff cuts (31 down to 19 nurses) last June have already saved the TDHB $600,000 p.a.
- This is **counter to the stated needs of the community to retain the ED and Hawera Hospital and the Government's wish for health services to be more convenient with greater use of community hospitals**, for minimal further total saving.

GP response 5

What we don't like……..

- **Rest home use for patients returning from TBH and the "Intermediate Model of care"**
- Patients would need to be well enough to return to the community, creating a huge "**bed blocking**" situation at TBH
- There are not enough doctors in primary practice in South Taranaki to cope with current needs, let alone additional Rest Home/Nursing Home responsibilities
- The "Intermediate Model of care" is another "no surprises" surprise that needs clarification, not thrown in as a "given".
- DHB physios and OTs do not know how community based rehabilitation is going to work when there is a perfectly good set-up at Hawera Hospital.
- The stated costs of $62,500 per rest-home bed does not include the cost of visiting and on-call medical, physio & OT services, nor does it realistically cover reasonable nursing costs as rest-homes & nursing homes underpay staff. It also assumes there will be an ability for the community to provide this service.
- This is counter to the stated needs of the community to retain the Hawera Hospital

GP response 6

What we don't like……..

- **There was only one model given to the 3 day Gemba workshop to work on.**
- Alternative models are needed as this model as promoted by management is not acceptable to Hospital, DN, GP staff & providers or to the ST community.
- "One size doesn't fit all" must be a basic principle as we have a varied population, rural country, rural town, varied ethnicities, ages and incomes (in every practice), different levels of insurance etc as well as different types of practice (large clinic verses small 1-2 doctor practice) and different government subsidies (from VLCA, through Interim Access to a non-PHO practice). **It is just not acceptable to have a model that is exclusive.**
- Common IT systems for South Taranaki are not feasible at present. Issues of privacy, different PMSs and security are not resolved. Current levels of electronic sharing need to be improved (eg Intrahealth doesn't link with Special Authority access).
- Forcing everyone into a system that isn't working is not sensible, it will increase costs and make retention worse, **counter to the stated needs of the community to retain GPs and the Government's need for efficiency**.

Kohia te kai rangatira, ruia te taiea

Gather the best, reject the bad

The Romatika Model

This model is aimed at improving GP access and continuity of care, simplified access to community health services, while reducing duplication.

It ensures that the RURAL Hawera Community Hospital remains as the “hub”, retains an Emergency service, In-patient beds etc while ensuring only those who actually need to access TBH facilities are transferred. Many concepts have already been promoted or planned, this just brings it all together.

The ED remains as is, or rebranded, but continues to offer Emergency Assessment and care.
However, inappropriate use is actively managed.

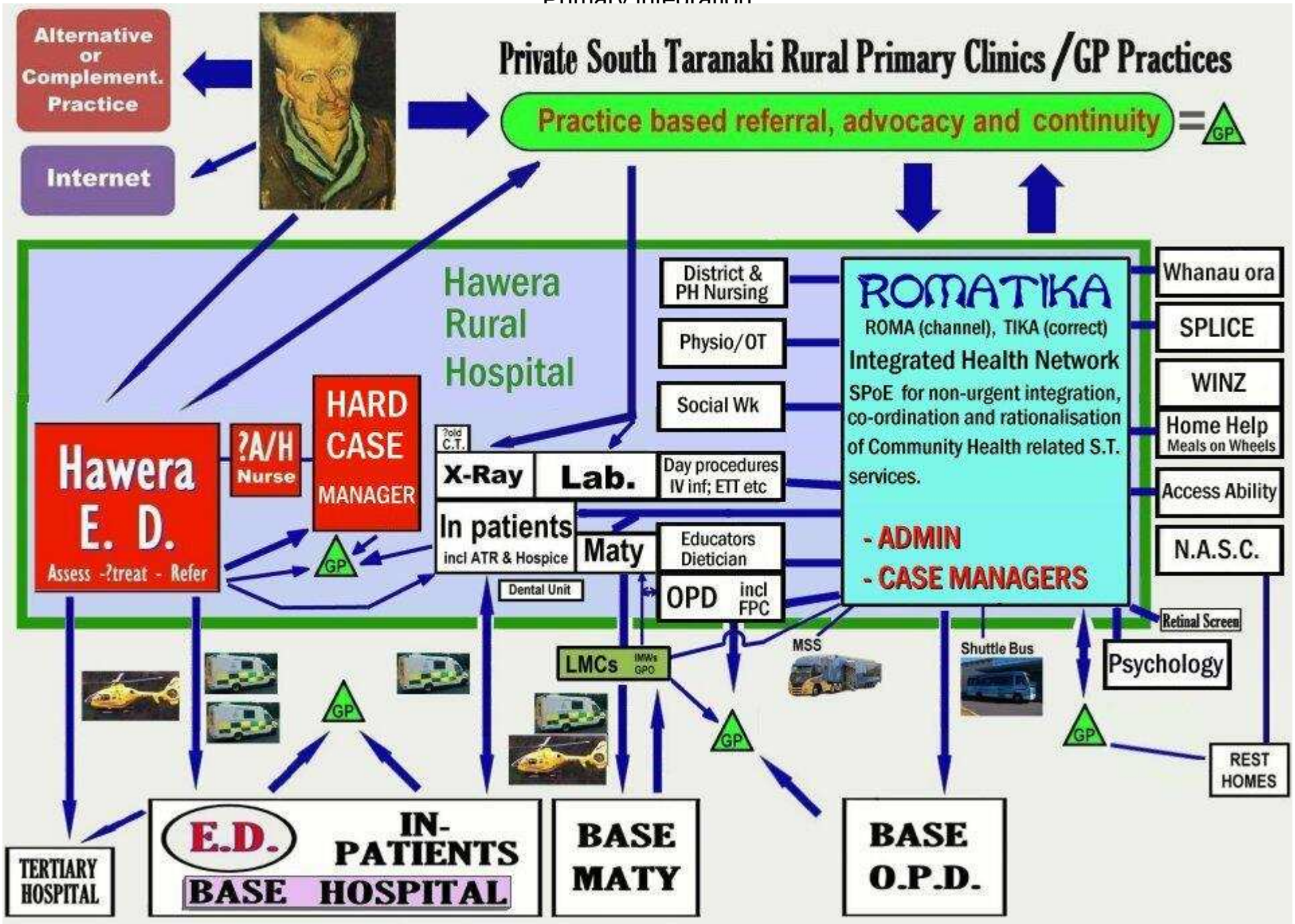
The concept is that all presentations are assumed to be an emergency until proven otherwise, so patients are triaged, seen and assessed. Non urgent cases are referred, either directly back to General Practice or to the HARD CASE MANAGER
No non-essential services are provided (eg only enough essential medication until normal hours) to discourage misuse.
The Hard Case Manager ensures access to a General Practice and/or to Access services (eg WINZ) via ROMATIKA.

A new Integrating Network is proposed, physically based at the hospital, to smooth and co-ordinate all community services. Case Managers ensure appropriate and more convenient services are involved.

This ensures the Flow or current (ROMA) for the patient is Correct (TIKA), hence the name:

ROMATIKA

Primary integration



GP response 7

What we like……..

- Maintains GP continuity through Romatika to make GP practice more efficient and rewarding [**Retention, Access**]
- Fairness to all patients of all practices [**Access**]
- Hardcase Manager to ensure a GP practice covers their capitated patients (even if just a repeat prescription until being seen) [**Access**].
- Hardcase Manager can give accurate information about GP availability directly to DHB (eg for need for Retention, Recruitment, Rural Ranking issues etc) [**Access**]
- Reduced inappropriate use of ED [**Efficiency**], makes MO job more satisfying and efficient [**Retention**]

GP response 8

What we like……..

- More efficient use of the Hawera Community Rural Hospital [**Efficiency, maintaining HH**]

- Hawera Hospital remains the Community Hub (Romatika), physically housing the administration and Case Manager staff, but virtually handling the work by organising and co-ordinating patients and providers for services based at HH (OPD, Physio, Day case etc), Base (OPD) or community (office, clinic, Rest/Nursing home, home) [**Efficiency, maintaining HH**]

- Does not stop SouthCare or any other practice functioning as a type of IFHC but they would access Community Health Services through the Romatika network [**IFHC plans**]. However, any PUBLIC FUNDED health services placed in an IFHC must be available free to ALL ST patients.

GP response 9

What we like……..

- Using one year of the annual $600,000 Hawera Hospital saving to purchase a second-hand CT scan. This would remove the need to transfer many patients, particularly the elderly admitted with a stroke. It would also reduce excessive travel as well as ensure the Inpatient unit remains viable. MO positions would be more attractive improving retention and recruitment of M.O.s (and probably GPs, Radiographers etc). [**Efficiency, Transport, maintaining HH, Retention**]

- It would be a “one off” cost, although a proportion of the HH savings could go towards maintenance and planning for future upgrades.

- It could allow TBH to upgrade its CT to a “state of the art” model, while using the old machine in Hawera (so already familiar machine for staff).

GP response 10

What we don't like……..

- Potential to create yet another layer of bureaucracy

- Potential for a "monopoly service" to fail to deliver if Case Managers and admin. staff don't have a good working relationship with hospital and Community Health service providers as well as GPs and Practice Nurses.

- Potential conflicts of interest whenever public and private services are "co-ordinated", so it will probably not be practical to directly book GP or private specialist appointments.

Integration of Romatika model

- Other models (Sarah to present)
- Using the best ideas from each model