Extended Care Teams

A holistic framework to measure service impacts and outcomes

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Ehara taku toa i te toa takitahi. Engari, he toa takitini.

My success is not that of an individual. Instead it is the work of the many.

Our Extended Care Team

- An interprofessional team working as an extension of general practice in the community
- Collaboration provides intensified care to support them to achieve their health and wellbeing aspirations
- Referrals from general practice, social service providers, or self-referral
- Genesis of this extension approach came from our 2006 workforce survey

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A multi-disciplinary approach

- Social Workers
- Clinical Pharmacists
- Dietitians
- Exercise Consultants
- Comprehensive Nursing team including CNS & NP’s
- Kaiāwhina & Health Coaches

Comprehensive Primary Care

- Health Improvement Practitioners, Health Coaches
- Full team working towards using same rating and outcomes measures
- Nursing team oversight for Kaiāwhina/ non-regulated workforce
- Nurse Practitioner
- Interdisciplinary meetings and packages of care
- Te Whariki Aroha collaborative

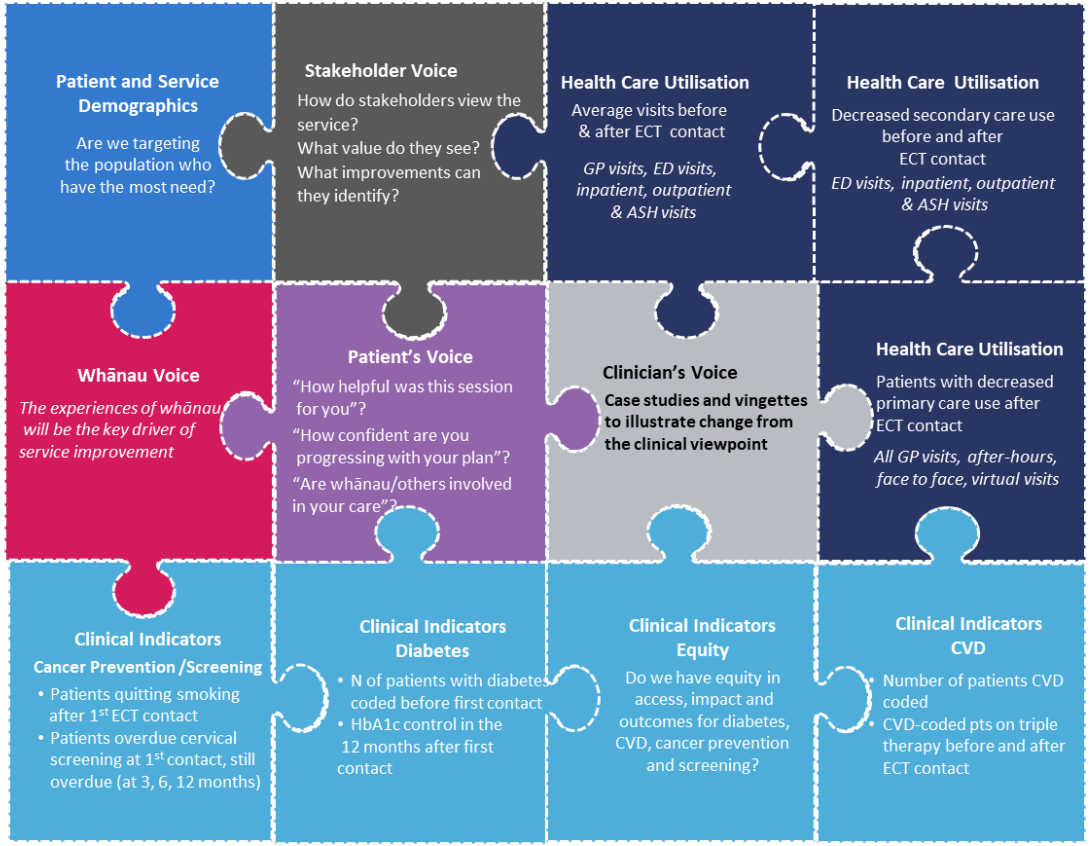
Initiatives

- Collaborative pathways
- Combined groups – moving past pain, pre-diabetes education and support
- Combined clinics – Child Health, Pop. Health and screening support
- Tane Takitu Ake ki Taupo tāne hauora programme, RESET
- Planned care - Fit for Surgery and Spirometry
- Iwi-led marae clinics

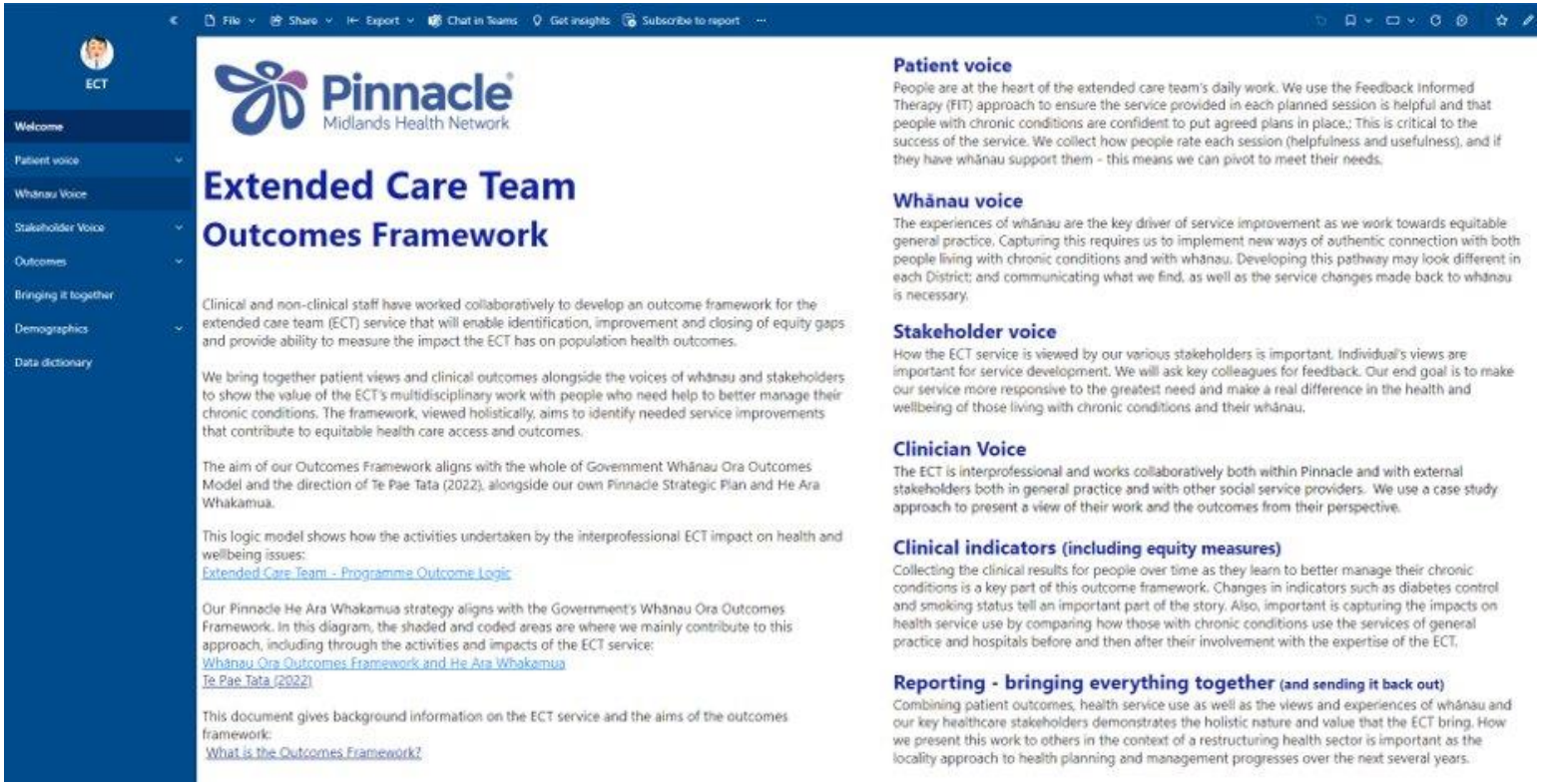
Developing an outcomes framework for this service

- Aim to bring together the patient, whānau and stakeholder voice alongside clinical outcomes
- Increase our focus on measuring service impacts and outcomes
- Insight into access and equity to inform service development
- Insights that highlight the contribution to population health
- Provide a more holistic reporting

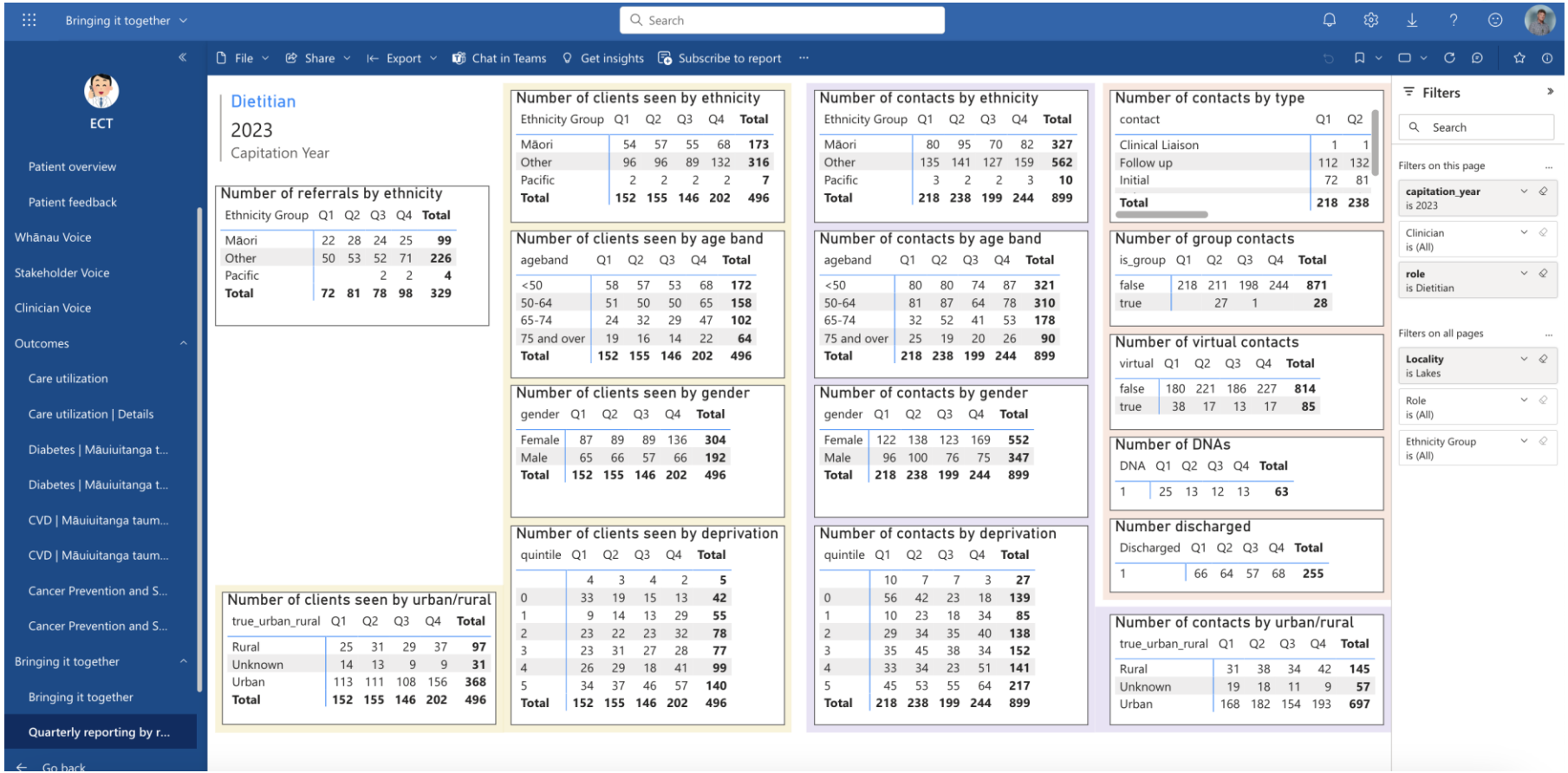
Outcomes framework – the jigsaw



Outcomes framework – the dashboard



Contract reporting – what is being done



Contract reporting – who is using the service

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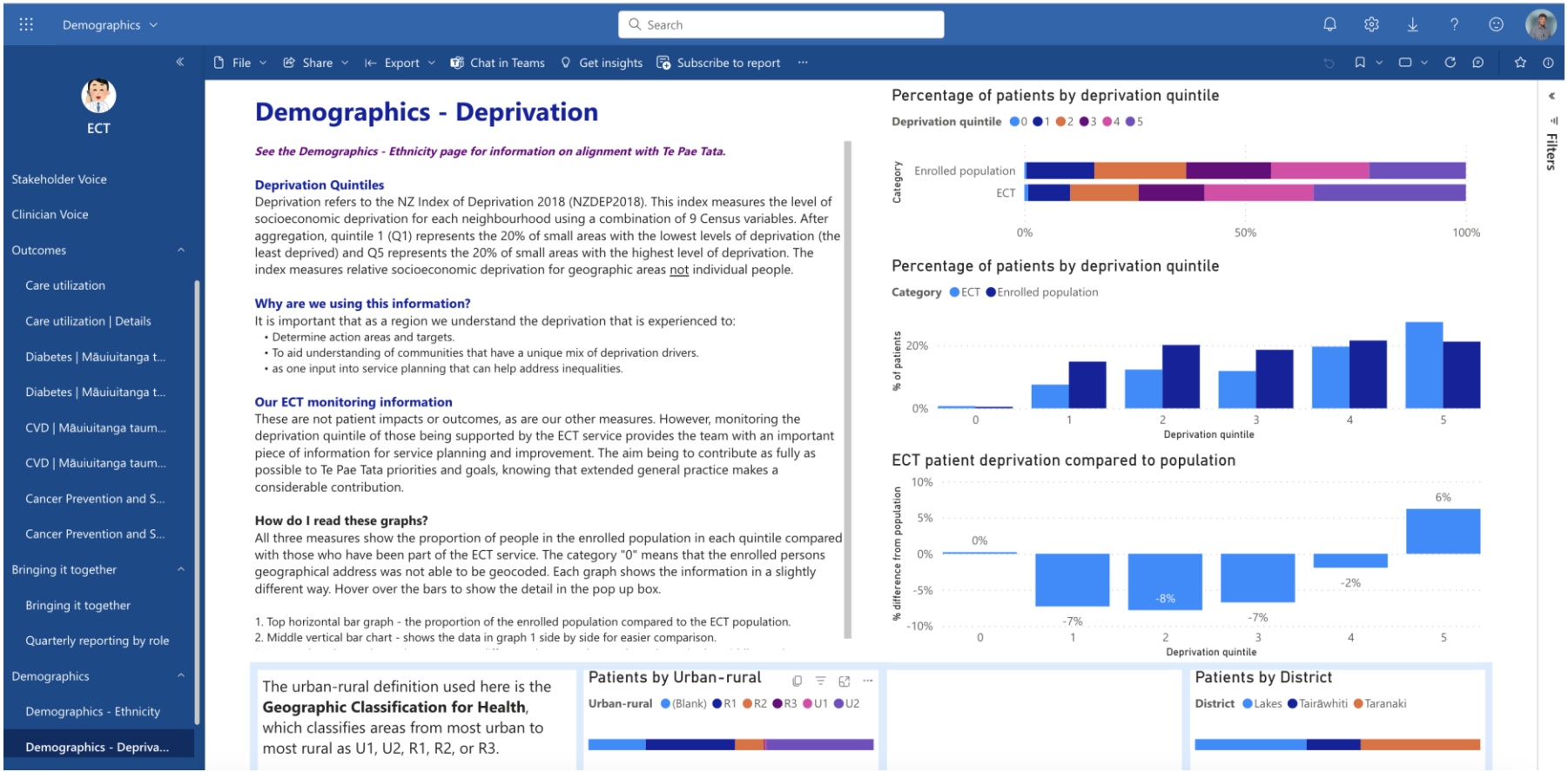
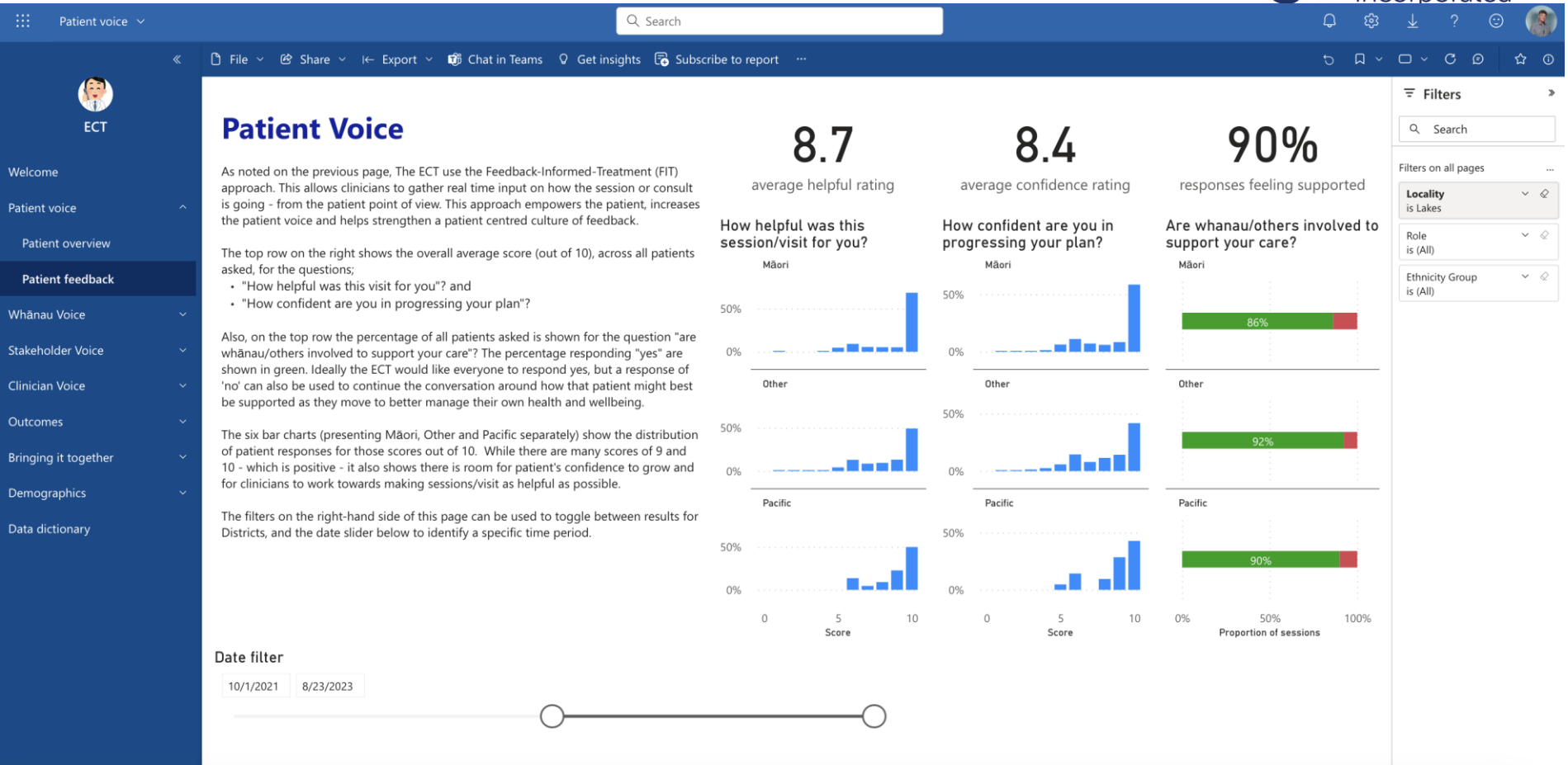
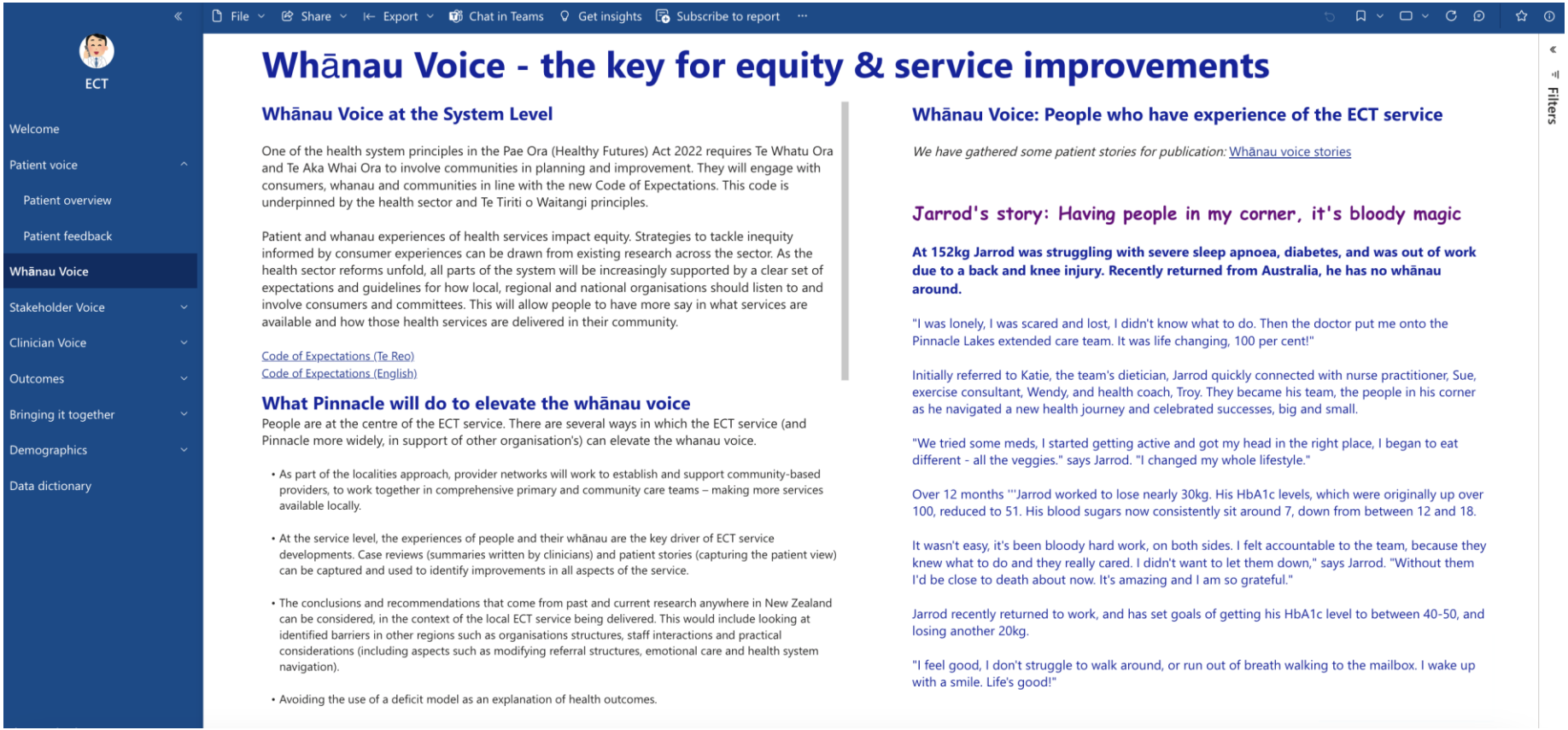


Patient Voice



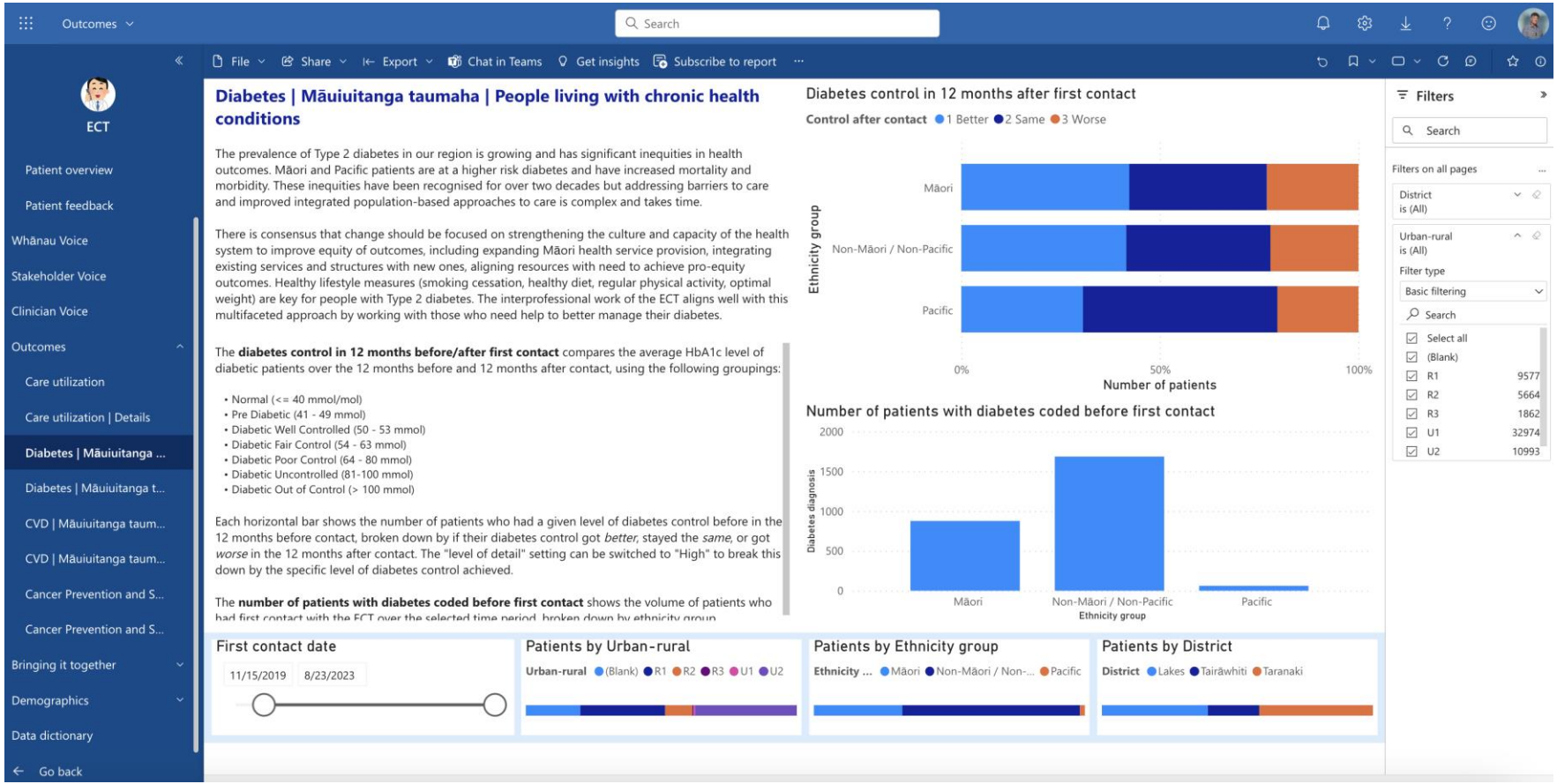
Whānau voice



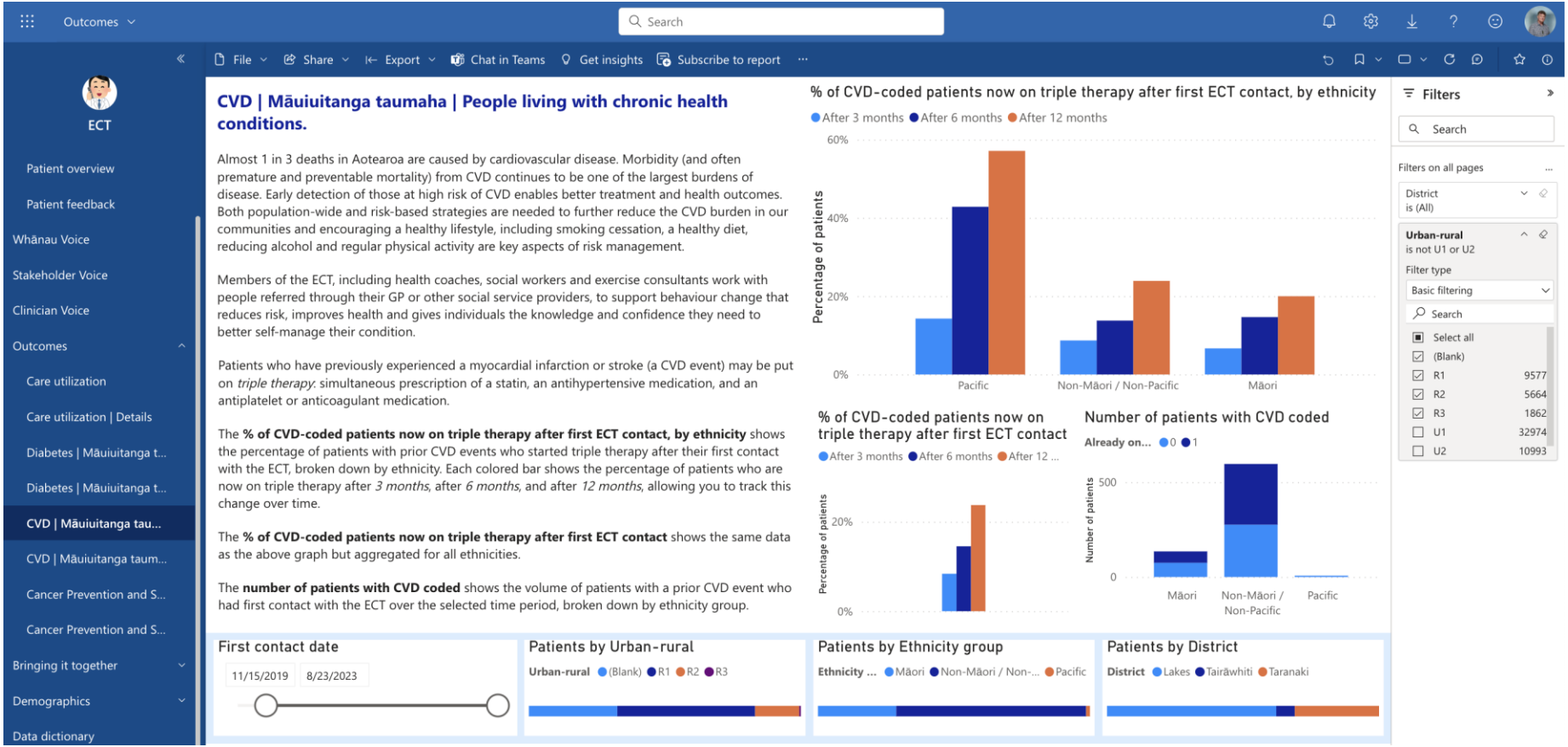
Utilisation report

Clinical Outcomes – cancer care

Clinical Outcomes – diabetes



Clinical Outcomes – CVD (rural)



Extended care teams

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2,503
dietitian consults

2,574
social worker consults

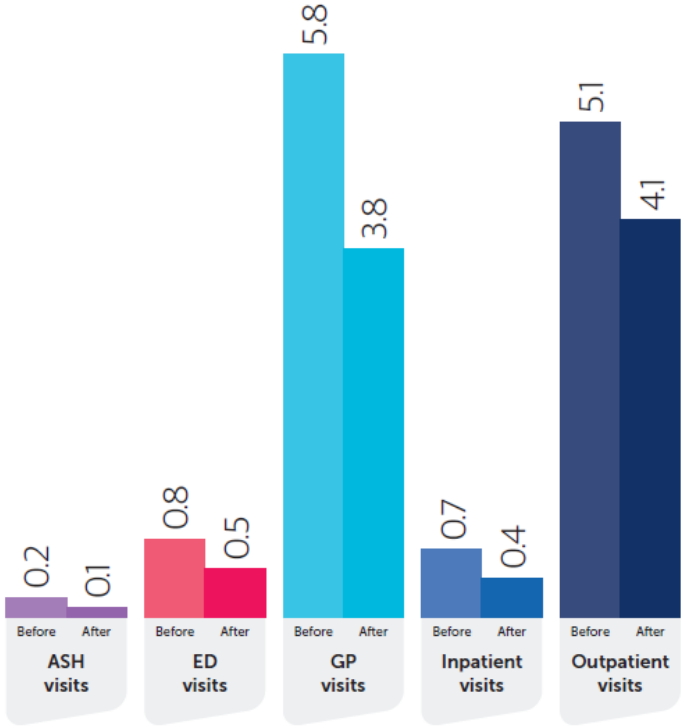
1,052
exercise coordinator consults

679
hauroa kaimahi (health coach) consults

1,583
clinical pharmacist consults

Average visits per patient in the 12 months before and after first extended care team contact

After working with the ExCT, a patient's utilisation of care generally decreases across various care providers, with notable reductions in GP and outpatients visits.

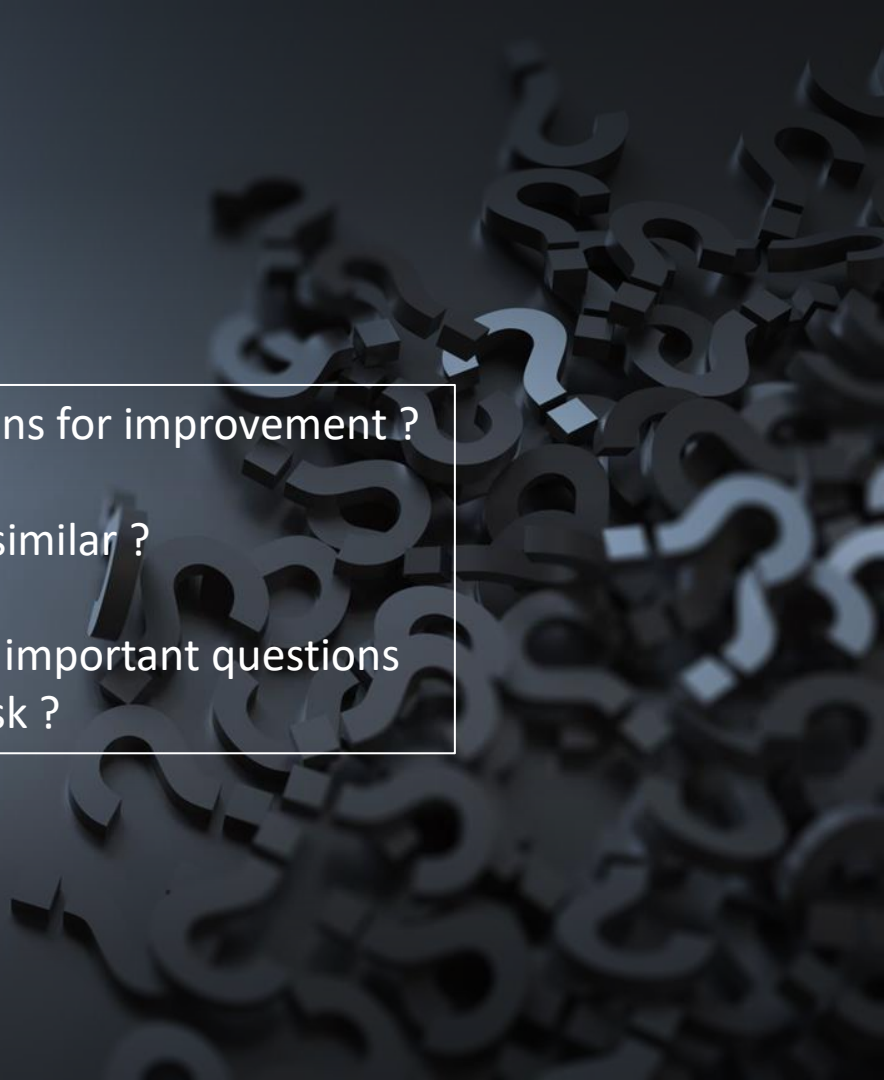


Questions ?

Comments – suggestions for improvement ?

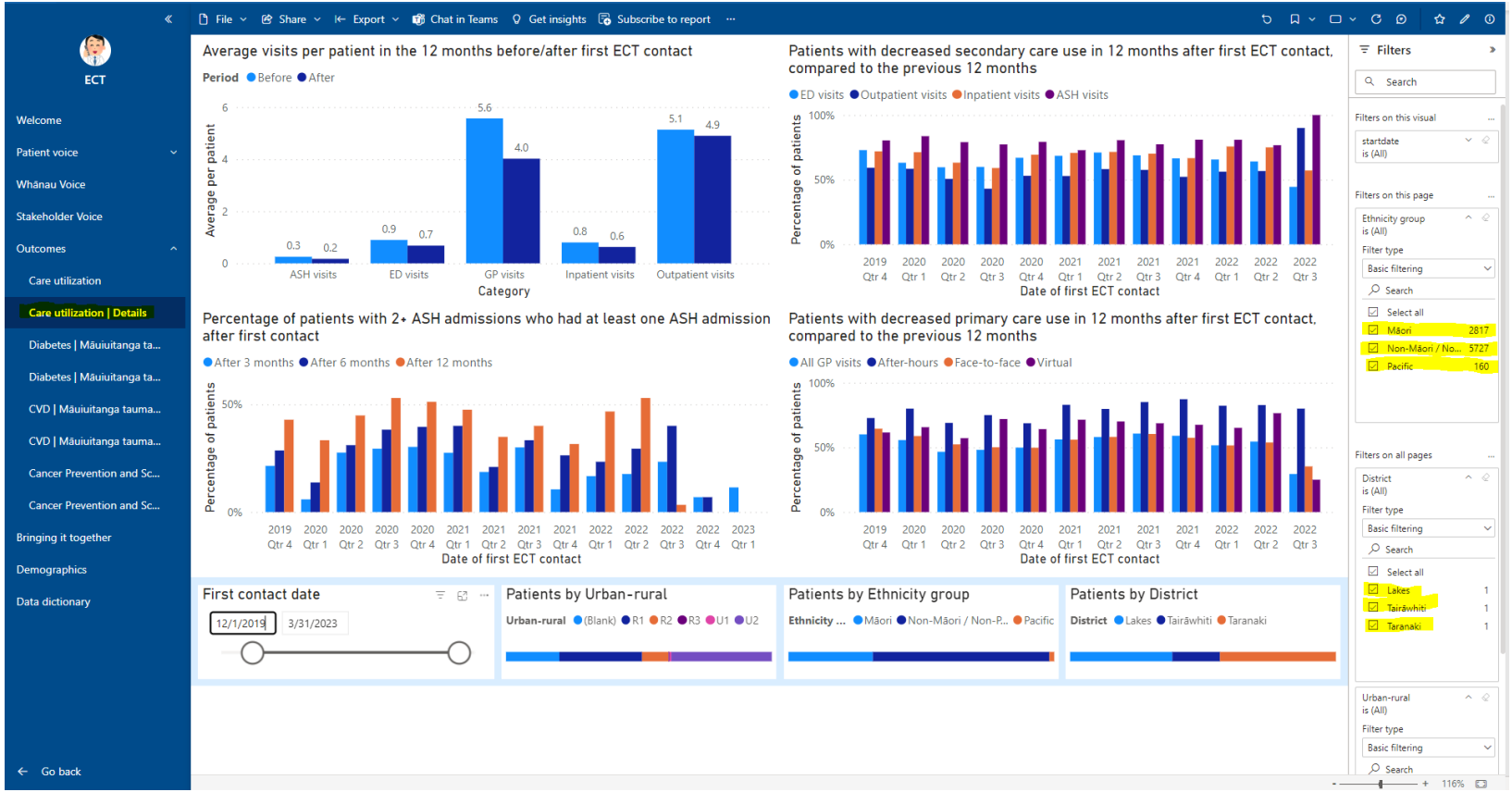
Do you do something similar ?

What are the clinically important questions you think we should ask ?



Spare slides

Healthcare utilisation dashboard



He Hoa Tiaki – Partners in care

Ngāti Tūwharetoa

Kaupapa o te iwi

- Tū-Whare-Ora
- Tū-Marae-Ora
- Taumaihīorongo