South Taranaki

Alive With Opportunities for Better Health Care

The "Roma Tika Plus" model

"*Better, sooner, more convenient*"

A blending of the best of the GP and Management models 2011

The Roma Tika Plus Model

- **Improved Access:**

  Patient access to all health services is improved by streamlining the flow (Roma) in the appropriate or correct (tika) direction by a new "Roma Tika Service" (Centre or Hub).

- **Compatibility:**

  This model is compatible with current Splice project, transport integration, Whanau Ora, Private Practice improvements and Integrated Family Health Centre plans.

- **Improved clinician retention:**

  Valuing clinical staff, particularly GPs, by ensuring they have the appropriate investigation, specialist input, treatment and referral options to provide both episodic and health maintenance services.

- **Better Use of Facilities:**

  Ensuring one of the best Community Rural hospitals in the country is not downgraded further by ensuring sustainable and enduring ED and Inpatient functions and a ST General Manager whose sole function is to ensure Hospital, Staff and GP retention.

This model is based on a number of Health needs assessments

- Rapid Health Profile
- Clinical Forums including GPs
- Bishops Action Foundation Report
- South Taranaki Business Analysis
- Responses to Management Proposals
- The massive public and local clinician support for a functional Community hospital with basic emergency services and in-patient beds.

Population & Health Profile

- Rising population of nearly 26,700 (**<u>25.4%</u>** of Taranaki) with higher deprivation, smoking, Maori, young, and birthrate.
- Similar overall hospital use to rest of Taranaki but higher use of ED, especially in office hours (problems accessing GP)
- Lowest GP:population ratio in North Island at 33/100k, 2nd worst in NZ after Westland.
- 50% attend small 1-2 GP practices, 50% larger clinics where access issues exist.
- Access to GPs the greatest identified problem, followed by access to specialist consultations and investigations.
- Retention of Hawera Hospital (including ED, OP, 20+ inpatient beds, Lab, Maty, HH District Nursing, 2ndary Dentistry) as a major identified priority. GPs want better access to investigations, specialists and simpler pathways.
- Problems with retention and recruitment of Medical staff (both GPs and Hawera Hospital Medical Officers).

The Roma Tika Service Centre (hub) is based in Hawera Hospital, (not in an IFHC) to enable co-ordination of all community health services for all practices where needed.

- **Appropriate patients are referred from their General Practitioner, or an In-patient ward or ED Medical Officer, mostly via the Practice Nurse or ward staff (respectively) to ensure TDHB employed Roma Tika Case Managers know what the medical and social problems are so that appropriate services can be initiated and co-ordinated. Many patients will not need this service if direct referral to a single service is all that is required and they have their own transport.**

- **Referral is by Fax or Electronically with patients assigned a Case Manager immediately, who contacts the patient as soon as possible in the community (eg in their home). Patients do not physically visit the Roma Tika service meaning the centre only needs an office and a small case conference room.**

- **Medical responsibility remains with the referring doctor until a clear transfer of responsibility and information occurs (eg the GP receives a discharge letter or phone call from a Medical Officer).**

- **TDHB employed Case Managers liaise with Outpatients (Hawera or Base), transport systems, SPLICE, District Nursing, Whanau Ora, NASC, WINZ, Access Ability, Home Help etc., and the GP team (GP-Practice Nurse) to ensure smooth pathways with minimal duplication, delay, travel and stress for the patient.**

The Emergency Department (ED) remains a 24 hour unit offering "crisis" Assessment and Care.
Waiting is not used as a tool to discourage inappropriate use, appropriate management is.

[See "Guidance for New Zealand emergency departments regarding the interface with primary health care" MoH June 2011 www.moh.govt.nz/moh.nsf/Files/ed-and-phc/$file/ed-and-primary-health-care-guidance-jun11.pdf]

- **The concept is that all presentations are assumed to be an emergency until proven otherwise, so patients are triaged (sorted by trained nurse) on arrival then seen in order of priority by the Medical Officer and assessed.**

- **Non urgent cases are reassured (often all that is necessary) and referred when appropriate, either directly back to General Practice or to the Roma Tika HARD CASE MANAGER who ensures access to a General Practice and/or to Access services (eg WINZ).**

- **In general, NO NON-ESSENTIAL SERVICES ARE PROVIDED (eg only enough essential medication until normal GP open hours, no certificates for work) to discourage using the ED as a General Practice.**

- **Admission from ED to in-patient beds at Hawera Hospital, or if appropriate Base, should not be restricted by artificial management definitions but by the clinical needs of the patient, meaning "flexibeds" in Hawera Hospital are a necessity, located where clinically appropriate.**

The Inpatient Ward at Hawera Hospital is not downgraded but adapted to current need and service options with 20+ flexible beds used and a supportive management.

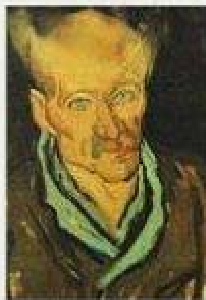
- **The proposal to reduce bed numbers makes no sense <u>financially</u> (economies of scale), <u>clinically</u> (Community generalist beds are safer), <u>socially</u> (particularly for Maori), <u>practically</u> (Rest home hospital level beds are cheaper for a reason, they are removed from the appropriate medical, nursing and rehabilitation staff and equipment needed for acute and early rehabilitation) and in terms of retention of Medical, Nursing and Ancillary staff.**

- **On site Medical Officers determine the best placement of patients (Base, Observation in ED, Hawera IP Ward, Rest Home (using Roma Tika Manager) or Home (with or without Roma Tika involvement). The flexible function of in-patient beds helps retain the ward.**
  - **Palliative and terminal care beds are needed in Hawera Hospital, as "Rest Home Hospital Level" care is often insufficient or inappropriate**
  - **short stay acute medical problems not needing specialist care but inappropriate for ED observation, mini-epidemics, etc.,**
- **Other uses of the "flexibeds" includes:**
  - **Overflow from Maternity when more than 4 need to stay**
  - **Day case procedures**
  - **Rehabilitation, after surgical or medical events that are stabilised at Base, can be continued in Hawera where there are appropriate staff and facilities, freeing up beds at Base to help reduce time in ED and reduce surgical waiting time, the two main goals set by the Minister of Health. These could include Central as well as South Taranaki patients. Transfer to Rest Home or own home can still occur when this level of care is no longer appropriate with community services organised by the Roma Tika Case Manager.**

A new South Taranaki General Manager position to replace the Hawera Hospital Manager

- In order to make services in South Taranaki robust, resilient and stable, the South Taranaki clinicians and population need to have management they can trust. Retention and recruitment also requires a trustworthy figure who will work to "make it so" when clinicians indicate a requirement rather than having someone tell them what to do (or not to do).

- This person must have the following requirements:
  - Be resident in South Taranaki
  - Be a Registered Nurse with a current Practising Certificate able to cover if needed
  - Have equal "status" to other General Managers, ie not be "down the pecking line"
  - Be able to report directly to the Board and it's subcommittees on matters relating to South Taranaki, rather than only reporting through the CEO.
  - Have a clear understanding themselves and from both the CEO and the Board that their role is an advocate for the south to management and the Board rather than the other way around (like an Ombudsman).
  - Essentially their prime function will be to ensure the facilities, services and clinician workforce in the south are supported, retained or improved.
  - The contract for the job will require the candidate to submit to initial and yearly re-appointment consensus approval of Hospital staff, two GPs (one representing SouthCare and one all other practices) and the HHCC. Without this approval the TDHB must find another suitable General Manager.



Private South Taranaki Rural Primary Clinics / GP Practices

Primary GP Services 1

- GP continuity of care is retained as the practice (or hospital Medical Officer) refers the patient to the Roma Tika service and Case Managers liaise with the GP practice directly to keep them informed and involved.

- GP practices can get on with seeing more patients if they are able to refer patients with complex social and medical needs to a service that co-ordinates care in the community.

- Access problems for patients attending ED inappropriately can be sorted by the Hardcase Manager (even if just obtaining a repeat prescription until able to be seen). This Hardcase Manager must also report to the South Taranaki General Manager with accurate information about access to GPs

Primary GP Services 2

- Direct access to investigations (eg urgent Ultrasound, CT, MRI) approved for GPs following established protocols with priority to urgency, not the origin of the request. (Vocational Specialist, Medical Officer, GP, etc)
  - Radiologists to conduct regular appropriate local CME for all doctors (GPs, Medical Officers) to ensure appropriate use.
  - Anyone ordering excessively or inappropriately can be audited and required to attend appropriate CME before having ordering privileges restored.
  - Considerable savings in both money and improved specialist access could be expected if the right people got the right investigation earlier.

- Easier direct phone and email access to all specialties by GPs is a privilege GPs value, will be of immense value for some patients and may help specialists identify areas of CME for GPs that is needed (as well as helping GPs identify their own CME needs).

Primary GP Services 3

“Integration” at practice level is supported for what is appropriate to that practice.

- One or more practices may wish to establish an Integrated Family Health Centre (IFHC), use phone and Internet prescribing and/or consulting and have patient access to their notes electronically.
- Other practices may believe these changes are not needed or appropriate or safe and may have other or better ways to improve patient access to primary services.
- Any additional funding or support for IFHC functions must also be available to smaller practices who often employ additional Practice Nurses to do some of the Diabetes screening & Reviews, Cardiac Risk Screening, Smoking cessation, vaccination, smear taking, liaising with pharmacists etc.
- PUBLICLY FUNDED health services for all South Taranaki should not be placed in an IFHC as it may unintentionally restrict access for the other 50% of the population.
- An IFHC should not co-ordinate services for other practices as all practices should access Community Health Services through the Roma Tika Centre at Hawera Hospital.

Negatives:

- Potential to create yet another layer of bureaucracy
- Potential for a “monopoly service” like the Roma Tika Centre to fail to deliver if TDHB employed Roma Tika 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 (eg Hospital) and private (GP/Specialist) services are “co-ordinated”, so it will probably not be practical to directly book GP or private specialist appointments.

Kohia te kai rangatira, ruia te taiea

Gather the best, reject the bad