

Better, Sooner, More Convenient Health Care in the Community



A better health service starts in the community

Each week hundreds of thousands of New Zealanders seek advice or treatment from the health service. Hospitals get most of the publicity, but the reality is that well over 90 percent of those interactions occur in the ‘primary’ sector – the doctors, nurses, pharmacists, physiotherapists and other health professionals working in your community.

It’s called ‘primary health care’ because it’s the first (and the main) place people’s health needs are met. In cases where a person’s illness or injury is too complex to be met in the primary sector, they are sent (or referred) to secondary care, most of which is provided in public hospitals.

The system works well by most overseas comparisons, but for decades has been held back by a lack of connection and collaboration. Health professionals working in the community (primary care) have generally been quite isolated from their counterparts working in hospitals (secondary care). Communication between the two has typically been distant and formal (mainly through letters and emails) and the systems for sharing health information about patients are limited.

In 2009 that began to change. A new direction in health policy, devised by the government and enacted by the Ministry of Health, was introduced.

The direction of that new approach was spelled out in the policy’s name: **Better, Sooner, More Convenient**.

That policy is now being used to create **Better** services for patients, through primary (community-based) and secondary (mostly hospital-based) health professionals working together more collaboratively – sharing patient information more readily and working together with patients to provide effective health care.

In effect the new approach is removing barriers and creating a continuous health service. After all, from the patient’s point of view, you don’t necessarily know (or care) who the person treating you is employed by – but you do care about whether the services you receive are good.

The **Sooner** aspect of the policy is self-explanatory; it involves less waiting for patients. By providing more services in the community and creating a smoother flow between different parts of the health service, patients can get treatment more quickly. For example: why wait weeks or months for a hospital appointment

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MANATŪ HAUORA

to get a skin lesion removed when, with some training, your family doctor (known as a general practitioner, or GP) can safely and effectively remove it today or tomorrow – and all you have to do is make an appointment.

The above example also touches on aspects of the **More Convenient** focus of the new approach. Most people live a lot closer to their local GP than they do to their nearest public hospital. It's almost always easier to arrange a time and day that best suits you at your local GP than it would be at a hospital. And for some services, especially for people with multiple long-term illnesses, assistance in the home or another convenient setting can help to ensure that they remain well in the community, avoiding unnecessary stays in hospital.

In combination, the new policy direction for health creates an environment where health professionals in the community are actively encouraged to work with one another, and with hospital-based clinicians to deliver health care in a co-ordinated and co-operative manner.

To help kick-start this transformation the Ministry of Health sought groups of community-based health professionals to take part in a series of demonstration programmes. Nine groups, which between them include the GPs, nurses and other health professionals who provide services to 60 percent of New Zealanders, are actively involved in these programmes, which give them more freedom as to how they use the financial resources they get from the government.

This booklet includes examples of the innovation and ingenuity which community-based health professionals have already brought to this new approach to health – things they are now able to do to provide better, sooner and more convenient health services to the people of this country.

This booklet is dedicated to New Zealand's primary health care workforce – the GPs, nurses, pharmacists, physiotherapists and other health professionals in our communities who are making a real difference in creating a better health service.

Hamilton GP John Morgan demonstrates a station where patients can check their own weight and blood pressure, and use the internet to check their test results and prescriptions.



Delivering more care within available resources


A major focus of current health policy is keeping people healthier in the community for longer.

This approach supports people to stay healthy and identifies problems earlier, when they can most effectively be addressed. It also benefits the health service, which is working to address rapidly growing demand for services.

People with a chronic illness like heart disease or diabetes and who receive good support and management of their illness in the community, are likely to stay healthier for longer and reduce unplanned hospitalisations.

Reducing unplanned admissions to hospital will be of growing importance in the years ahead as the proportion of the population who are above retirement age increases.

Demand for health services will significantly increase – there's no stopping that. But by spreading that demand across the whole health system, using the full skills of the talented clinicians in our communities, and supporting people to stay healthier in the community, it is demand which we will be able to manage.



A single day's medication for one of Carterton pharmacist David Holt's complex customers (page 11). Many people with long-term illnesses face an equally complex array of medicines each day.

Using a team approach to do more

One of the key goals of the Better, Sooner, More Convenient approach is freeing up highly trained health professionals to focus on people with complex health needs.

That requires doctors, nurses and other health workers to work together more closely, and in some cases to train others to do certain tasks or procedures.

Treatments which were once hospital-only are increasingly being performed in the community by GPs and practice nurses who have received additional training from hospital specialists. Examples you'll see in this booklet include intravenous antibiotics to treat the serious skin disease cellulitis, surgery to remove skin lesions and giving GPs direct access to diagnostic imaging (instead of having to refer patients to hospital for that imaging).

GPs themselves are sharing certain roles with other health professionals. For example, until recently only doctors could write prescriptions. An increasing number of nurses are undertaking extra education to become nurse practitioners – a role which enables them to assess patients independently, to diagnose and write prescriptions.

In many general practices, registered nurses are also doing further education and training, and managing the care of patients with long-term conditions in partnership with GPs.

In turn, nurses can also pass some time-consuming tasks on to people with less training – enabling nurses, who are highly trained and skilled professionals, to spend more of their time on patient care.

And it isn't only health professionals. With the right training people with no formal health qualifications can perform work which helps



Melissa Bennett takes a throat swab from six-year-old Sahara.

protect the health of the community – and which would otherwise require a large chunk of a nurse's time.

For example, in Kawerau, Melissa Bennett and her colleague Liisa Wana, have been trained by a district nurse to take throat swabs. Between them Liisa and Melissa visit schools in and around Kawerau twice each week – swabbing children who have sore throats.

The swabs are sent away for laboratory analysis, and, if the bacteria linked to rheumatic fever is detected, doctors quickly prescribe antibiotics and let the families know to pick them up – free of charge – from the nearest pharmacy. Quick treatment with antibiotics can save the child from a lifetime of ill health and serious heart problems in adulthood.

In one of those schools more than one-third of children with sore throats had the bacteria, but thanks to quick detection they were given antibiotic treatment before serious problems could develop.

Case study: Waikato

Patient care starts at ‘Hello’

Ask Hamilton GP John Morgan about the traditional approach to patient care and you won't hear much in the way of nostalgia.

‘The traditional approach was people making an appointment to see a doctor – with patient care not starting until they met face-to-face.

‘GPs were booked solid with appointments. We had virtually no time to plan care, or respond to phone calls. The frustrations were huge, and our reception area used to be a horribly noisy place with phones ringing all the time.’

In 2011 things have markedly improved in the NorthCare Pukete Clinic, where Dr Morgan works.

‘Patients now begin receiving care from the moment they pick up the phone.

‘Their calls are answered by an outside call centre to reduce noise and distraction in our clinic. The call centre, which is run by St John with support from registered nurses, can book appointments for people – or arrange for them to receive advice via phone or email.

‘This new approach allows GPs and nurses to set time aside for these “virtual appointments” by email or phone. Our goal is to develop a care plan for every patient, which we now have the time to do.

‘Of course patients can see a doctor or nurse anytime they want, but most seem to appreciate that this new approach provides care sooner and more conveniently, which saves them time and money.’

The new approach also sees the clinic's staff – doctors, nurses, a clinical pharmacist, medical care assistants and others – working much more collaboratively to plan patient care, including team meetings (they call them ‘huddles’) before each day's work begins.

Improved planning produces many benefits. For example, patients are now often being sent for lab tests before their GP appointment, speeding up the process of diagnosis.

John Macaskill-Smith is the CEO of Midland Health Network, which developed this new approach.

‘To meet the incoming wave of increased patient demand, health services need to be brave in changing the way things have traditionally been done.

‘This new clinician-led and patient-focused approach has reinvigorated people about being a GP or nurse, and that's what we need to do,’ John Macaskill-Smith says.



Medical care assistants like Janice (at left) are a new feature at Pukete – recording patients' basic information and vitals before they see a GP.

Case study: West Coast

Closing the distance



New telemedicine equipment which is being used across the West Coast is enabling patients to link up with GPs, hospital specialists and others – who may be hundreds of kilometres away.

On the rural West Coast a trip to the GP traditionally involved a long drive – and seeing a hospital specialist could require several hours on the road each way.

That's changing, thanks to modern high-definition video links – which are being deployed in eight towns up and down the Coast – from Karamea in the north to Haast in the south.

Those towns have medical centres staffed round the clock by rural nurse specialists who provide most of the care. A GP is only on site one day a week.

In the past if a patient needed to see the GP they often faced a six-day wait or a long drive to one of the provincial centres.

Greymouth GP Greville Wood says patients in those towns are now able to book a video link – with a GP or specialist in Greymouth or Westport.

'The nurse stays with them during that hook-up to carry out any measurements that may be required, to support the patient and to begin planning follow-up care.

'It's surprisingly good – tonnes better than a telephone. I've actually found that some patients can speak more freely over this video

link. I don't know why that is but they discuss things they would never have discussed face to face. Although it is still an important part of the relationship that we do see them in person when possible,' Dr Wood says.

Using these video units – known as 'tele-medicine' – includes a second handheld video camera, so the doctor can see things like skin lesions or rashes in extreme close-up.

Jenny Robertson, who manages Buller Health in Westport, says advances such as this help them to cope with a chronic shortage of doctors on the Coast.

At Buller Health, which is open 24 hours a day, GPs provide their expertise not only to their patients, but also to patients in overnight beds in places like their acute medical ward.

'It's very exciting the way GPs are working alongside staff from the health board in teams,' Jenny says. 'A year ago we introduced a shared patient record, so people caring for a patient can see the full picture when providing treatment.

'We don't talk about primary health and secondary health on the Coast – we just talk about health,' Jenny Robertson says.

Case study: Palmerston North

Getting to know you

Most people only go to see their GP or practice nurse when something goes wrong – an upset stomach, a sore foot, a chest infection.

The problem with that traditional approach is that health professionals often have limited information to form a true picture of the patient and to plan their care accordingly.

At Amesbury Health Centre, in Palmerston North, they realised that there isn't enough time in a 15-minute consultation to really get to know patients – so they did something about it.

They began inviting older patients, aged 75 years and up, to the centre for a free hour long sit-down with a practice nurse.

Jane Ayling, a nurse who worked on the project says it was astonishing how much they learned about those patients – many of whom had been coming to the health centre for a decade or longer.

'We thought we knew them really well from that long-term interaction, but we found out an incredible amount about them – their physical activity, what happens in their homes, their diet, their transport needs and more,' she says

'The initial trial has now turned into a process of nurse-led care plans which is being rolled out across 42 GP practices in the MidCentral area.'

Practice nurse Jan Leggett (with GP Murray Shaw at right) meets face-to-face with older patients to prepare individualised care plans.



'Based on that information the practice nurse, in consultation with the patient and sometimes with a GP, works out an individualised care plan for each patient.'

'Charlie' (not his real name) – is in his 70s and has been a regular at Amesbury for some years. Like many others, his interactions have been brief, focusing on his needs when he felt unwell.

'This assessment was very informative for me as a patient. I never realised I could do so much more to improve my health,' Charlie says.

In line with the care plan, he's now taken up some light physical activity, and foresworn the slice of cake he used to have each day for afternoon tea.

The initial trial has now turned into a process of nurse-led care plans which is being rolled out across 42 GP practices in the MidCentral area. Amesbury is now doing the assessment on all new patients aged over 75 who have known long-term illnesses.

Case study: Mount Wellington

Creating an Integrated Family Health Centre

‘I have dreamed about this since the day I first walked in here, in 1996. I wanted to buy the video store next door and turn it into a one-stop-shop for health services.’

Those words, spoken by Dr Joe Williams – Medical Director of the Mt Wellington Integrated Health Centre – are coming true as he speaks them. Workers are busily creating spaces for a dentist and a radiology service – while work is under way to bring more hospital-based specialists to the centre to run clinics for their patients (they already have specialist clinics for mental health, orthopaedics, eczema and smoking cessation up and running).

At the time we visit the centre has GPs, practice nurses, pharmacy, physiotherapy, minor surgery and a number of other activities under one roof.

‘It’s more than just being in the same building though,’ Dr Williams says. ‘They belong to the

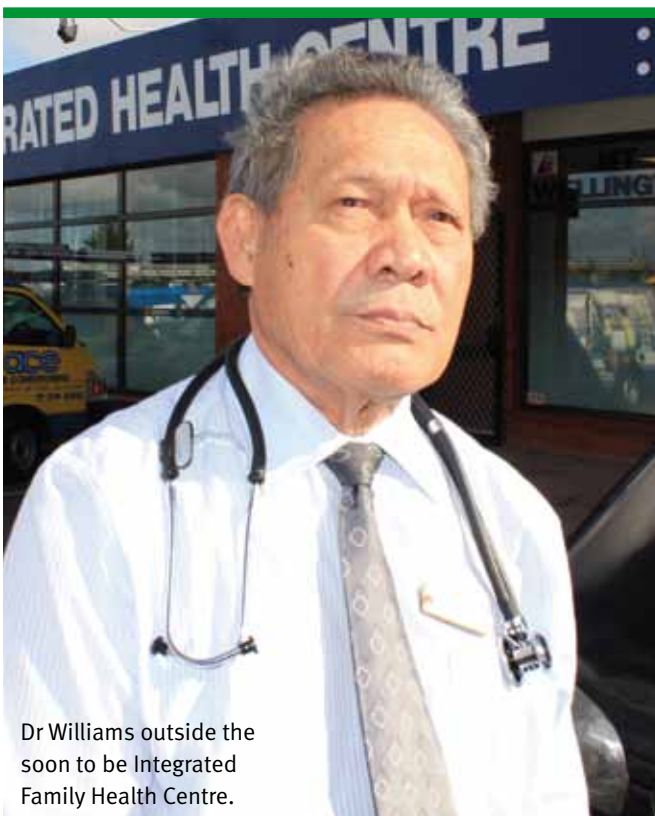
clinic, and the clinic belongs to them – there is a sense of being family.’

‘This began becoming a reality thanks to the Better, Sooner, More Convenient policy – which encourages the creation of Integrated Family Health Centres (IFHCs) such as this.’

The convenience factor for patients is obvious. Imagine going to your GP with a sore ankle. He orders an x-ray to rule out a fracture. The x-ray gets sent back to the GP, who says you need physiotherapy and some pain relief. In the normal course of events that scenario could see you criss-crossing town for hours – GP to radiology, back to GP, to physio then to the pharmacy.

Once Mt Wellington’s IFHC is completed later this year you could do all of the above under one roof, with clinicians who work together to share ideas, strategies and information to get you better, sooner.

That’s one of the benefits of an IFHC. As Dr Williams puts it, ‘It’s a one-stop shop, the patient is the focus and everyone does their part to create the best care possible.’



Dr Williams outside the soon to be Integrated Family Health Centre.

‘It’s a one-stop shop, the patient is the focus and everyone does their part to create the best care possible.’

Case study: Opotiki

Re-entering the world outside your door



Pat Cosgrove (at left) checks in with Hilda and Jimmy Brown.

Jimmy and Hilda Brown's farmhouse in Opotiki has been their home and their castle since the mid-1950s. It's the place they raised their six children – a modest house but rich with love and memories.

Sadly, for Hilda, those memories are starting to fade. She has mild dementia, coupled with a chronic lung condition which tethers her to an oxygen source almost 24 hours a day.

'It can be isolating,' Hilda says. 'I can't just get in a car and drive off to Whakatane like I could a couple of years ago.'

That may be an understatement. It's several years since she last interacted socially with people outside the family home and it's clear that Hilda has lost confidence.

That may be set to change, thanks to a care plan developed by Pat Cosgrove, a senior registered nurse from Te Whiringa Ora Care Connections – a service which specialises in developing individual care plans for people with chronic illnesses and coaching them to better understand their medical conditions.

As part of their Better, Sooner, More Convenient approach, the local health organisation

commissioned Te Whiringa Ora to help people like the Browns.

Pat worked with the Brown family to develop their care plan. It addresses Hilda's health needs, for example, teaching her exercises, arranging a home visit from a specialist respiratory nurse and working to get a more portable oxygen supply. The care plan also seeks to address her other needs, for example, arranging some gentle social outings.

Hilda is nervous about the latter, but with ongoing coaching it seems she is readying herself to take those first steps back into society.

Jimmy admits that the help is a weight off his shoulders. The sprightly octogenarian had never cooked until a few years back but now the kitchen is his sole domain. As is the milking shed: at 87 years of age he still milks the cows seven days a week.

But his main job of recent years, providing round-the-clock care for a loved one, would be enough to tire out someone half his age.

'It's a great service, and it's been making a big difference,' Jimmy says. 'The mere fact that someone is providing this sort of care takes some of the pressure off me.'

Case study: Wairarapa

Getting the mix right for patients

Keeping track of your medicines is a complex business and getting it wrong can have negative – or even disastrous – effects.

In the Wairarapa it's an issue they're taking seriously, with innovative projects to help people remember which medicines to take and when – and also ensuring clinicians consider the effects of combining medicines.

Local GP Anne Lincoln and pharmacist David Holt have played key roles in the projects, which focus on people with complex medication needs – often older people with several longstanding health problems.

'The more pills you're on, the more likely they are to interact with one another,' Dr Lincoln says.

Those interactions are so complex that even experienced clinicians sometimes need a reminder – and one Wairarapa project is doing just that.

The process was designed by Professor Tim Maling, who reviews the medications and case histories of some of the most complex patients. He meets with their GPs to discuss the cases and suggests strategies to improve the mix of their medicines and eliminate interactions.

'Many GPs have applied those lessons to other patients in their practice,' Anne Lincoln says.

'We've already helped 700 of our most complex patients in this way and the project is going wider across the district.'



Carterton pharmacist
David Holt

David Holt is playing an especially hands-on role in another project – where patients with complex medication have their dispensing cycles synchronised.

'A lot of them have one prescription running out next Tuesday, two the following Friday, and three at the end of the month. By aligning all those dates people can much more easily keep track of their total medicine needs,' David says.

'We've already helped 700 of our most complex patients in this way and the project is going wider across the district. We can even remind people when their supplies are running low and when they need to get a fresh prescription,' David Holt says.

That focus on people with complex health needs is widespread in the Wairarapa – with health professionals across the district working closely together to focus resources on those who need it most.

Case study: Auckland

Faster access to diagnostics

X-rays, ultrasounds and CT scans can be vitally important in diagnosing what's wrong with a patient. However, gaining access to these tools can sometimes be an uphill battle for GPs.

That's changing in Auckland, and in other parts of the country where GPs are gaining the ability to directly order complex medical imaging for their patients.

They do that using a computerised tool which is now available to all GPs in the Auckland District Health Board (DHB) area and which is in the process of being rolled out across the city's two other DHB areas. The tool helps GPs to determine what medical imaging is needed, and to request that imaging.

Similar tools are used in Canterbury, while Wellington GPs have a different but comparable approach which enables faster access to

diagnostics. That latter approach is set to roll out into the MidCentral DHB region in the near future.

Dr Gary MacLachlan, a GP at the Stoddard Road Medical Centre in Mt Roskill was an early adopter of the new Auckland tool and says it has already helped many of his patients.

'As an example, an MRI is an important diagnostic tool for a patient with headaches, where you suspect there may be a serious underlying cause. We used to have to refer that patient to the waiting list for a hospital specialist clinic – because only the specialist could order an MRI. It was a slow and ponderous way to get there.

'Now, with the new electronic tool, if the patient meets the diagnostic criteria, or if I discuss it with a specialist, we can get that patient in front of an MRI machine in a much more timely fashion.



‘This new approach can save the patient months of uncertainty and in some cases months of pain. Most importantly, it reduces the delay in accessing appropriate treatment – because waiting for a scan can mean waiting for the cure,’ Dr MacLachlan says.

Most of the referrals are to hospital radiology departments, but under the new approach GPs are also allocated funding to make use of private providers. GPs can use some of that funding to send patients who should not wait, or cannot travel to the DHB, to contracted private providers.

‘Patients have been quite blown away with this. In the past they’ve had to go through a hospital process first, or pay for the test privately, which many patients just can’t afford,’ Dr MacLachlan says. ‘I’ve now got some patients checking back with me two or three times because they find it hard to believe they won’t have to pay for the test.’

The new tool also lets GPs know instantly if their patient qualifies for the imaging they’ve requested.

‘GPs who are still using the old system, writing a note requesting an image, have to wait until my colleague Dr Barnett Bond and I manually review those requests,’ says Dr Jim Kriechbaum, a GP who works with Auckland District Health Board.

‘Using the computerised system gives certainty to the GP and the patient sooner.’

The software tool also offers advice and recommendations on what tests should be carried out for patients who don’t currently meet the diagnostic criteria for a scan.

‘There’s definitely an educational aspect to it,’ Dr Kriechbaum says. ‘The aim is to ensure that the people who would benefit most from medical imaging, wait less time.’

The new approach also benefits the hospital system by reducing the number of referrals to outpatient clinics. Those patients who do go to an outpatient clinic are managed more efficiently because they have already had their investigation.



Reducing the waiting time for medical imaging should also help to reduce the high number of patients who don’t turn up on the day for their radiology appointment.

‘Historically, around a quarter of patients don’t show up for non-urgent ultrasounds,’ Dr Barnett Bond says. ‘After six months, they’ve often sought alternative treatment, the problem has resolved itself or required more urgent treatment, or it’s no longer something that they’re paying much attention to.’

‘When people don’t show up you have radiologists and sonographers standing by with no-one to image, while other people wait for their turn.’

‘A lot of work has gone into checking people still want their appointment, and the number of people not turning up for non-urgent ultrasounds has now dropped from 25 percent to 5 percent,’ Dr Bond says.

Mt Roskill GP Gary MacLachlan says the benefits of a more efficient system are already beginning to flow through to patients.

‘In the past patients had a six-month wait for non-urgent ultrasounds – which is a long time to wait if you have something like gallstones. When I look at my computer now, this tool tells me that the waiting time for non-urgent ultrasounds has halved. That’s a positive change,’ Dr MacLachlan says.

Case study: Christchurch

Rebuilding strength and confidence

Around 18 months ago Christchurch retiree Josie Madden suffered a serious fall, breaking several bones.

Josie says regaining confidence after that fall was her biggest battle. But her confidence, and her physical stamina, has improved markedly since she joined a falls prevention programme last year.

‘Oh heavens yes,’ says the quick-witted pensioner, ‘it’s made a great difference. Without it I would have lost my independence and the ability to live in my own home.’

Community-based physiotherapist Jacqui Bath says prevention is always better than the cure.

‘Tripping and falling are major causes of injury among older New Zealanders. A serious fall can rob them of their mobility, their independence and confidence,’ Jacqui says.

‘When a new patient is referred to us, often by a GP or practice nurse, we visit them in their home and identify any possible tripping hazards – be it rugs and mats which aren’t secured, appliance cords, or things like having the phone a long way from where the person usually sits – which can result in injury if they hurry to answer a call.

‘It’s also important to work with other health professionals in the community. For example, we look for risk factors such as complex medication which might cause the patient to become dizzy or disoriented – then consult with the person’s GP and pharmacist if we sense a risk to the patient.’

Jacqui is one of nearly 100 physiotherapists in Canterbury trained to provide falls prevention programmes in older people’s homes.

Jacqui is passionate about the work she does. ‘As a physio you spend your entire life fixing people who are broken – it’s really nice to be able to help people to avoid becoming broken.’



Physiotherapist Jacqui Bath takes Josie Madden through her paces – using leg weights to improve her strength and balance.

Eliminating risk factors and improving the confidence, balance and strength of people like Josie, reduces the likelihood of serious falls in future.

Working together to improve older people's health

Below: Hospital geriatrician Shankar Sankaran (centre right) meets with GPs and a nurse practitioner from the Pakuranga Medical Centre in Auckland to discuss older patients with high health needs. Scenes like this will become more common around the country as more hospital specialists work in GP practices to help patients identified by the GPs as needing additional care and support.

Dr Sankaran meets with some patients and, for others, he discusses support strategies based on the patient case notes.

'It's a learning experience,' Dr Sankaran says, 'I learn from the GPs, and they learn from me.'

'These types of initiatives enable GPs to manage their patients better in the community and to avoid unnecessary hospital admissions. It's a true example of better, sooner, more convenient primary health care,' Dr Sankaran says.

Pakuranga GP Eileen Sables (at left) says the joint sessions are of real value. 'It's absolutely great for our patients and for us. The patients I've spoken to love it because they can meet with these experts at their local GP clinic, they don't have to leave the area.'

The Pakuranga Medical Centre also works with a hospital-based psychologist who runs regular clinics from their premises. They hope to continue adding to the team who spend time on-site working directly with them.



Case study: Auckland

A boost for community-based treatment



More and more parts of the country are now allowing patients to be treated for cellulitis in community-based medical centres, which used to be a hospital-only procedure. Treatment, seen here at East Care A&M in Howick, Auckland, involves giving the patient intravenous antibiotics.

The Better, Sooner, More Convenient approach has produced a lot of innovations (as seen elsewhere in this booklet) – and it's also given a new lease of life to some existing systems.

One of these, known as Primary Options for Acute Care (POAC), seeks to reduce hospital admissions by allowing a wider range of treatments to be given in the community. In Auckland, the number of people receiving POAC care jumped to 15,000 last year, up 50 percent on the previous 12 months.

'If a condition can be safely managed in the community, then it makes sense to do that,' says Dr Mark Morunga, head clinician at East Care Accident & Medical Clinic in Howick. 'Of the patients we used this approach with last year 87 percent were successfully treated in the community.'

Across Auckland 91 percent of patients who were surveyed said they preferred the POAC approach over being admitted to hospital.

'The system allows us to treat patients who may have conditions like asthma, pneumonia, gastroenteritis-dehydration and cellulitis.

'The patient only pays for the initial GP consultation. Anything we organise for them after that – like ultrasounds to rule out deep vein thrombosis, chest x-rays to check for pneumonia, or lab tests – is at no charge to the patient.'

Dr Morunga says the new direction in health policy has raised awareness of POAC and has increased support for this approach from hospital clinicians.

Cutting edge care in the 'wop wops'

Kiri Henry lives deep in the heart of Tuhoe country – surrounded by verdant hills and bird song, but with not a neighbour in sight.

'Welcome to the wop wops,' she greets us, a warm smile on her face.

It is a magnificent location, pure New Zealand countryside, the best kind. But it's also a long way off the beaten track, which can be dangerous if you have lung disease and heart problems.

Seven times in the past year the rural solitude has been split by an ambulance siren as Kiri was rushed to hospital.

She now has a sophisticated way to carefully track her own health – despite her physical distance from the nearest hospital. Those results are also beamed back to the watchful eyes of her case manager – a registered nurse at Te Whiringa Ora – a service which develops individual care plans for people with chronic illnesses.

It was through the trusting relationship the case manager built with Kiri that she was willing to try out a special computerised device which would help her to better self manage her health. A tele-health monitor was installed in her home allowing her to measure her pulse, blood pressure, lung capacity, lung function, electrical activity in her heart and other health indicators.

Kiri takes a series of measurements each day, in the comfort of her own bedroom. Within weeks of starting to use this 'tele-health' device her case manager had used its data to book a visit for Kiri from a respiratory nurse, a referral to her GP, a meeting with a district nurse and a respiratory nurse, and a session with a podiatrist.

The aim is to help Kiri get treatment before things get to the point where hospitalisation is required. 'The caring they've committed to me has been a real blessing to me,' Kiri says.

A sophisticated medical device, not much bigger than a fax machine, has enabled Kiri to more effectively manage her own health.



Case study: South Auckland

Anne's story

Anne Talagi – born in Niue and proud of it – has been in New Zealand since before she could even walk. She grew up to be a strong independent woman, a hard worker and an energetic mother to five children.

Then five years ago fate struck a cruel blow. Anne had just started a job which involved lots of heavy lifting and noticed her breathing 'wasn't right'.

The diagnosis was grim – a serious lung disease which initially required surgery to remove most of one lung.

'It left me unable to work, on a benefit, sitting at home doing nothing. That's just not who I am,' Anne says.

In the years since that diagnosis Anne has endured an ongoing battle with her illness. 'I've had a lot of lung infections and lost a lot of weight. I know my health isn't going to get any better and I've already seen far too much of the inside of hospital rooms.'

Anne isn't alone, as thousands of people live with chronic illnesses.

'Often there are other underlying problems – perhaps poor housing, inadequate diet, or problems with their medication – which, if better managed, might keep them in better health,' says Professor Harry Rea, a specialist in respiratory medicine. He played a key role in developing a collaborative project between community-based GPs and the local district health board, Counties Manukau.

The project identifies people who frequently end up at the emergency department at Middlemore Hospital, or being admitted to the hospital – a category Anne fell into as a result of frequent lung infections.



Anne Talagi

'Once the patient has consented, doctors, nurses, social workers and others look at the way they live and decide if they might benefit from support in their day-to-day lives – perhaps home visits from a pharmacist to teach them how to effectively use the medications they take, or support from other agencies such as WINZ or Housing New Zealand.

'The wonderful thing is we're improving the quality of life for those people. No-one wants to spend half their life in hospital,' Professor Rea says.

Anne agrees. 'Through this new system I now receive hospice palliative care including regular contact with a nurse. I'm happy with how they treat me and being able to have a dialogue with them is important to me.'

Case Study: East Tamaki

Going in with ‘wise eyes’

You can see the depth of commitment in their eyes as they vividly recount stories of the people they are helping.

The four person team, from East Tamaki Healthcare, work as ‘clinical family navigators’ who specialise in going into the homes of high-need patients to ensure plans are in place to address their health and social needs.

Between them the four women – Belinda, Anamafi, Vaisiliva and Fifi – have nearly 80 years’ experience in nursing and midwifery. But only one of them, Fifi, is registered to practice nursing in New Zealand.

Gillian Davies is the head of nursing for East Tamaki Healthcare, a network of 14 medical practices in Auckland that serve over 105,000 people. ‘About a year ago we realised that overseas-trained people, who may not be registered here, could bring a wealth of experience to this role.

‘It’s also an opportunity for them to use existing skills that weren’t being used otherwise. When they go into the home of a high needs patient they go in with wise eyes. They can see what the whole story is and raise the flag to registered nurses so we can start taking action straightaway,’ Gillian says.

The team members say it’s satisfying to be able to use more of their skills. When they spot an issue – like a patient having difficulties with their medicine, suffering from poor nutrition or inadequate housing – they quickly alert the clinicians (registered nurses and GPs) who work alongside them. Care plans are developed by registered nurses, and work begins with health professionals and with social agencies like WINZ and Housing New Zealand.

It’s work the team does with persistence and with dedication.

As Anamafi – who for 25 years was a nurse and midwife in Tonga – describes the living conditions of one of her current clients her voice breaks to a sob, and a tear rolls down one cheek. She’s quick to recover her composure – there’s work to be done! That very morning she began a vigorous campaign to get that man a better home.

One thing’s for sure – if you were in that man’s shoes you’d want someone like Anamafi on your side. With her decades of commitment to patient care and her dogged determination, you know it won’t be long till that client’s problem is addressed.

Belinda sums up what everyone on the team is feeling, ‘We can make a real difference. It’s work we’re proud to do.’



Making a difference: clockwise (from top) Fifi, Vaisiliva, Belinda, and Anamafi.

Case study: Auckland

Giving patients what they want



Renee Muru (left) primary health care manager for Turuki Health Care, says meeting people and home visits are a key part of their Whānau Ora service approach, which aims to put a complete package of support around people's health and social needs. 'In simple terms, health problems are often closely related to things like housing, income, education, transport, employment, nutrition and smoking cessation,' Renee says. 'It's important to see the whole individual in the context of their whānau. By collaborating with other agencies we can address the factors that contribute to ill health, make a positive difference, and get some great outcomes for whānau.'

'Responsive' would be a good word to describe the team at Turuki Health Care in Mangere, Auckland.

A case in point – they noticed a number of patients needing antibiotics because of poor oral health. Flash forward and around the time this booklet is published two dental chairs will open for business in Turuki Health Care, offering dental services at a low cost. A dispensing pharmacy will open on-site around the same time.

That type of response to patient need typifies the Turuki approach. Another example – they noticed the high amount of stress being experienced by new mothers whose babies had a condition known as 'tongue-tie'. Those infants have difficulty feeding because a fold of tissue under the tongue is too tight.

The solution is simple – a single snip with a pair of surgical scissors, but there was a hospital waiting list for that procedure.

A few months later, a GP at the clinic is now performing that procedure, often on the same day the problem is diagnosed – having been trained to do it by a hospital specialist.

Te Paea Winiata, chief executive of the service, says the wide array of services recognises the fact most of their patients, an equal mix of Māori and Pacific, have complex or high health needs.

She says the current approach to health has given clinicians more flexibility to shape services from the bottom up – 'tailoring services to the people we serve, rather than being confined to a 'one-size-fits-all' approach.'

'It's an exciting development that we are actually participating in the conversation,' Te Paea says.

Detecting diabetes

Diabetes is rampant in the Pacific community but groups like the Tongan Health Society in Auckland are fighting for the health of their community by focusing on early detection.

The Society operates three medical clinics in Auckland, including Langimalie Integrated Family Health Centre in Onehunga – where over 13 percent of patients have been diagnosed with diabetes.

Screening all new patients enables rapid detection of diabetes, even before there are

symptoms. Staff at Langimalie can then begin managing the disease to create better health outcomes for their patients.

Those with diabetes are given a full education including advice on diet, foot care, and medications. The centre also raises awareness of the illness and other health issues through health days at each of the 42 churches in the area they service. Health committees are established in each of those churches to promote important health issues such as cervical screening, exercise, nutrition and diabetes.



All new patients at Langimalie Integrated Family Health Centre are screened for diabetes. Here, nurse Limiteti Tu'imana performs the standard finger prick test.

Case study: Horowhenua

Working together



Specially trained nurses like Sylvia Meijer are part of a multidisciplinary team which visits older patients like Robert Hyde-Smith in the community to fully assess their health needs and make arrangements to see these are met.

Local GP Chris Fawcett makes no bones about it: provincial centres around the world have a hard time attracting, and retaining, GPs. Levin is no exception.

At the Horowhenua Health Centre they have adapted to that challenge and are creating a strong local health service.

The key came with a nationwide change in health policy two years ago, which gave community-based health professionals greater flexibility in how they can use available funds to meet the needs of their communities.

Dawn Wilson is helping to drive a series of changes which are turning neighbours into colleagues.

‘For over four years we’ve shared premises with staff from the local district health board who

deliver a range of services including mental health, rehab, maternity and older people’s care.

‘We were working in the same location and serving the same community. But we weren’t really working together.

‘In the past year a culture change has really started to happen,’ Dawn says.

Chris agrees. ‘A lot of things can be solved through conversation and those conversations are now beginning to take place.

‘We have a joint clinical governance group and clinicians from both public and private sectors are attending the same monthly clinical workshops.’

‘It’s about reducing the barriers between so-called primary and secondary care. Our commitment is to care – full stop,’ Chris says.

Case study: Canterbury

In sickness and in health

Harry Bolland and his wife Sonia tied the knot before Elizabeth was queen, before Elvis made his first record, and more than a decade before New Zealand's first TV sets flickered into monochrome life.

The pictures on the mantel in their immaculately kept Christchurch home show Harry, Sonia and family throughout the 62 years since they exchanged their vows. For richer, for poorer, in sickness and in health.

Harry's conversation remains lively and engaging, but chronic illnesses have taken their toll on his

body. That's a hard reality to face for such an independent man – a successful businessperson until the combination of lung, heart and circulatory diseases forced him to retire – at the 'tender' age of 82.

Their family provides support, but the bulk of day-to-day activity falls on Sonia. She's thankful for the government-funded support she receives from the local branch of care service Nurse Maude, which expanded its programmes last year in line with the new direction in health policy.

Harry now receives a Restorative Programme, which has seen him visited in the home by a variety of health professionals – including an occupational therapist, physiotherapist, dietician, district nurse and a stroke rehabilitation team – who all work in close liaison with his GP. The programme aims to restore quality of life to Harry, and to help him avoid unnecessary hospitalisations.

As Sonia explains, 'His goal was to be able to walk to the end of the street, which he's now achieved. Before that he couldn't even walk to the letterbox.'

Harry is pleased with the progress. 'The concept is excellent. It's been amazing, it's made the world of difference.'

Sonia too feels a sense of relief, mainly through an hour or so of practical assistance six days a week from a Nurse Maude support worker. Most days that's Karen Rush.

'Things like helping Harry to get showered and dressed were beyond me, and Karen's also really helped Harry's mobility with regular walks,' Sonia says. 'We have full confidence in this system.'

The practical help from support worker Karen helps Harry and Sonia Bolland to remain independent and together in their own home.



Harry Bolland and wife Sonia on one of his daily walks, under the watchful eye of Nurse Maude support worker Karen Rush (at rear).

Kevin Woods, Director-General of Health

As the recently appointed Director-General of Health, I'm delighted to see the way clinicians around the country are working together to improve the care provided to New Zealanders.

The formerly sharp division between primary (community) care and secondary (hospital) care is becoming increasingly blurred, as clinicians and health planners work more closely together across the health system. This integrated approach is key to creating the best health outcomes for patients and to making maximum use of the resources available.

Likewise professional boundaries are changing – enabling tasks to be done in a way which frees up the time of our most highly trained professionals and our hospital system to focus on patients with the most complex needs.

The innovations and approaches featured in this publication are part of an integrated health care system that continues to deliver results for patients.

In example after example we see clinicians in the community playing a larger role in designing services which meet the needs of the communities they serve. This freedom to devise strategies which



work for specific communities is at the core of the Better, Sooner, More Convenient approach – and those working on the frontlines in our communities are best placed to assess what works for the population they serve.

While some noteworthy successes have already been achieved, I look forward to working with people across the spectrum of health services to deliver continued improvements that will benefit all New Zealanders.