KARE Project:

Improving the care of older people living in Waitematā

Factors for success

Waitemata District Health Board
General Practice

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KARE Project

- The purpose of the KARE Project was to develop and evaluate a comprehensive package of interventions to help keep older adults healthier so they can stay at home longer

- Nine General Practices 2015 – 2018
- 1,186 patients (95% of target)

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KARE Interventions

- A comprehensive assessment identifying **patients** health concerns/issues.
- A tailored **patient centred** care plan developed with a focus on home and/or community based interventions
- Funded flexible care coordination by the practice nurses enabling phone calls and patient reviews at 6 and 12 months
- Transition of care funded consult post hospital discharge

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Co-Design

- Iterative process for KARE design.
- Initially a strong "population health focus" - but it was not owned by general practice -
- Appointment of clinical leader and project manager for implementation
- Pause… critique – what is the problem ? Potential solutions. Input from:
    - Patients
    - GPs, Practice managers, nurses
    - Secondary care – geriatrics, medicine, community services
    - PHOs
    - Academics
- Redesign to work in general practice setting… limited co-design
- In future would invest in a more formal co design process with practices and patients from the beginning

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Project Structure

- A clear lean project structure to enable rapid decision making and buy in
  - A dedicated Project Management resource (project manager and clinical lead) helps to keep the project on track
  - A Steering Group – governance (key stake holders)
  - An interdisciplinary project team, with strong clinical leaders positive attitude, transparent, robust debate encouraged
  - A clinical sub-team to plan/resolve detail/practice by practice issues assisted tailoring practice support
  - An understanding of the timeframe needed to implement change in primary care

Clinical and business model alignment

- For any primary care based project to succeed, the clinical model of care and business model need to align.
- Success factors
  - It has to be a “real” problem for primary care
  - Not a pilot - a long term commitment with a 10 year time frame enables changes in models of care while minimising the business risks of investing in extra staffing and system changes
  - Work with committed / engaged practices
  - Potential solutions with individualised practices determining model of care – no one size fits all
  - Dedicated budget for project implementation/practice time reflecting true costs e.g. overheads, no double dipping

Implementation

- Facilitated by a practice team doctor, nurse and manager
- Factors for success:
  - practice by practice variability/tailoring to develop a range of delivery models
  - Flexibility of timeframes for practice implementation to fit in with pressure of practice workload. A “stop… pause… reflect”
  - Problem-solving with the clinical sub team on a practice by practice basis
  - Process of sharing learning between practices (e.g.workshops)

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Workforce development

- Empowerment of nurses a key focus and critical for providing care for highly complex patients in a sustainable manner
- Factors for success:
  - Time and space within the practice
  - Nurse led patient centric care (issues from assessment) vs medical model
  - Support of critical thinking/ problem solving
  - Supervision sessions/patient specific review sessions to increase nursing skills and knowledge with practice nurse and GNS
  - Greater understanding of community based services

Clinical Team

- The model of care focused on holistic/patient centred care is more complex than single clinical issue projects and requires greater team work
- Factors for success:
  - Clear understanding / respect of roles
  - Shared consultations GP/ Nurse
  - Patient centered verse medical model
  - Effective communication – face to face vs electronic
  - Home based assessments
  - Geriatric Nurse Specialist clinical coaching within practice setting

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Results - Annual review

- Patient feed back positive
- *Partners In Health* self management scale
- Improvements in self-management perceptions of ‘knowledge’, ‘coping’, ‘management’ and ‘adherence to treatment’.
- 12 month follow up
  - Fewer falls, increased use of mobility aids
  - Fewer reports of “concerning pain”,
  - A decrease in anxiety and depression
  - Fewer concerns about medications, and greater use of blister packs
- General Practice stakeholders
  - Enabled staff provide care in a more proactive way focusing on patient concerns and home issues equip patients to manage changes in their clinical status

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Listen and learn

- Lean start up with core elements and be open to change
- Factors for success
  - Respect and understanding for General Practice
  - Ongoing communication with practices enabling flexibility and individualised practice problem solving
  - Encourage critic, everyone's feedback is important
  - Learn from mistakes and adapt as required

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