Community Health Networks

Central organising point in the CCDHB Health System Plan

CCDHB
2018

Astuti Balram. Manager – Integrated Care. Strategy, Innovation & Performance Directorate

Community Health Networks –Central organising point in the CCDHB Health System Plan

Contents

1. What is a Community Health Network?

"Community Health Networks are the central organising point for the delivery of effective and efficient healthcare."

CCDHB Health System Plan 2018

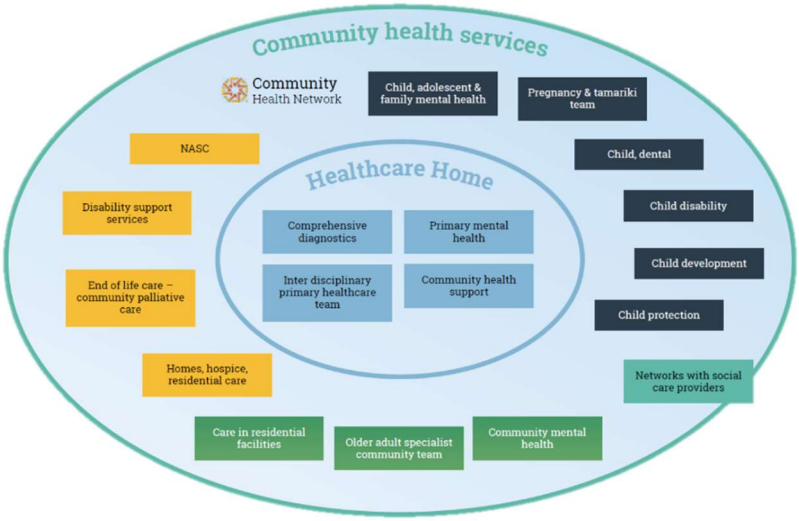


Fig 1. Community Health Network as per the Health System Plan

Healthcare is delivered in a variety of settings and Community Health Networks will deliver more care in the community, closer to people. Networks will link health services to deliver the right care to the right people in their community. As identified in the Health System Plan, Networks are CCDHBs mechanism to organise the delivery of health services to meet the needs of the population in the network.

Each Network will generally include 20,000 – 50,000 people supported by enhanced primary health care services and specialist services. The Network will include a grouping of Health Care Home practices at its core service with robust connections with other health services relevant to the population. The Networks will as a collective deliver better preventative care, pro-active care, acute care and after-hours access. They will provide a collection of services to support them in the community and be a conduit for further support from the hospital services as needed.

Eight Networks will be established in specific geographies across CCDHB based on demographics, health need and physical proximity. Māori and Pacific populations have been identified across each Network and improving services to support their health needs will be a key focus for the Networks.

To establish Networks across CCDHB we will need a collective commitment to a new way of care delivery in the community. We will need to progress the roll-out of the Health Care Home model, enable specialist services to work in the community, implement new infrastructure, deploy enablers and adapt an ongoing learning environment to the changes.

The Networks are complimentary to the locality approach within the CCDHB Health System Plan. The locality approach will focus on partnering with the community to maximise benefits as a collective.

Networks are a key component within the CCDHB Health System Plan and align to the principles of care in the community, working together, creating efficiency, innovation and acting early.

2. Who are the key partners in developing Community Health Networks?

The Community Health Network concept was developed as a key component of the CCDHB Health System Plan. The Health System Plan was built through engagement with the sector and will be implemented in partnership with the sector.

The development of this Network framework has been through a collaborative approach supported through the CCDHB Integrated Care Collaborative (ICC). The ICC includes the Primary Health Organisations (PHOs), the hospital health service, mental health hospital services, Māori Health Directorate, the Pacific Health Directorate and Strategy, Innovation and Performance Directorate. Consultation with Ngāti Toa about the Network framework has been included as part of this development.

Following the development of this framework that describes the Networks for CCDHB, implementation plans will be completed. This phase will require wider consultation with the community, service providers and key stakeholders in each Network. This wider engagement will be maintained in the ongoing implementation of the Networks into the future. This will strengthen the links with the locality approach.

3. Why do we need Community Health Networks?

3.1. Community Health Networks will deliver on the quadruple aim

Community Health Networks will include and deliver services tailored for particular population groups and particular health needs. It will allow us to build on the benefits that the Health Care Home model and other service improvements are demonstrating for the population and system. The Networks will focus on improving outcomes for populations who currently experience inequitable health outcomes, particularly Māori and Pacific.

Goals and targets will be tailored to each Network and incorporated into each Network's outcome framework. These goals will be linked to the overarching system wide goals driven by key partners in CCDHB, including the DHB and PHO Executive Leadership Teams and the Integrated Care Collaborative Alliance Leadership Team. The system wide goals for the Networks will be measures by ethnicity and are as follows:

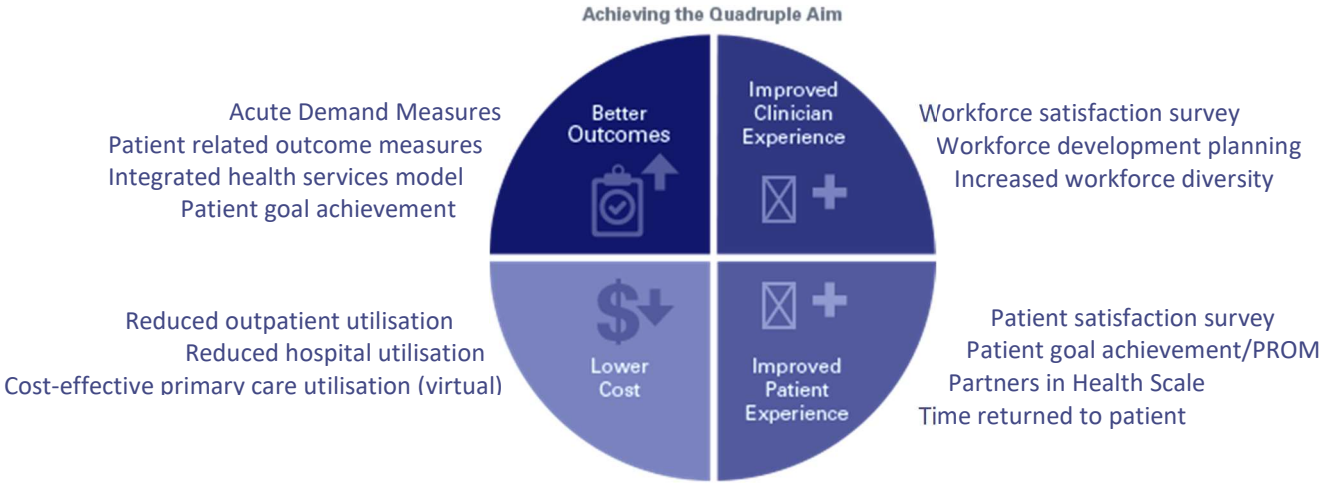


Fig 2. Community Health Network outcome measures

These measures will be underpinned with relevant process and quality measures that will enable the implementation of the Networks to be closely monitored.

3.2. Community Health Networks will build a strong system, rather than focus on individual services

People access primary health care, specialist care and various other support services for their care. Many people have their health care needs met in the community and some access the hospital for periodic specialised care. Community Health Networks will provide an infrastructure to organise health services for people closer to the community.

The Networks core will include a group of Health Care Homes as they are an accredited model that delivers even better primary health care. The Health Care Home practices are delivering a new model of primary health care to provide better pro-active, preventative and acute care for people in the community. The number of practices that are developing into Health Care Homes is growing in CCDHB. The aim is to reach 80% of the CCDHB population by the 30 June 2019. The Health Care

Home practices provide a robust platform into which other services are being connected and further services will be connected.

Specialist services such as District Nursing and Allied Health services are connected with Health Care Homes already. Further services such as Palliative Care Co-ordinators and Co-ordination Centre Case Managers have more been recently been aligned with Health Care Homes. Health Care Home teams are also engaging with other specialist services for collaborative care planning.

The Networks will provide the organising infrastructure to provide better primary care and specialist services in the community. They will create a system, rather than focus on individual services to deliver a number of benefits including the following:

- People have multiple health needs and to achieve better patient related outcome measures service integration is required. The Networks will support services to collaborate together around the needs of the patient, rather than the patient seeking support from multiple services to get support for their different needs.
- Networks will be have population based health outcomes which can only be realised through the collective action of various health service providers.
- Health Care Home may vary in areas of specialisation. Networks will formalise the relationships between Health Care Homes so they can refer to each other (horizontal referrals) for support with specialised skills and services.
- The number of hospital specialist services are limited. The Networks will provide a consolidated point of contact for specialist services. Specialist services can connect with a smaller number of Networks, rather than individual primary care practices and/or Health Care Homes.

.

3.3. Community Health Networks will enable a more services to work in the community

The CCDHB Health System Plan and national Health Strategy call for service delivery closer to where people live. Community Health Networks will provide the infrastructure that will enable services to connect through the following:

- Each Network will include a particular population with known health care profile within a geography. The services will be able to tailor their services and models to better meet the needs of the specific populations in those particular areas.
- A group of accredited Health Care Home practices will form the core of each Network. Other services will have assurance for high standards of quality of primary care that they would be working closely with.
- Governance and quality improvement processes with be established for each Network to ensure that as a collective they are improving population health. Other services will be able to understand the benefit of being part of this new way of working and be assured that quality processes are underpinning the collective services.
- The Network management infrastructure and enablers will support the ongoing connectivity of services

These aspects of the Networks will support new services participate and be a partner in delivering better care in the community.

4. What are the design principles for establishing Community Health Network?

The principles driving the CCDHB Health System Plan will drive the Community Health Network design. Communities, whanau and people are the central focus for Networks. Working together, innovating, creating efficiencies, simplifying and intensifying based on the populations heath needs, as well as shifting to supporting the person earlier in their health journey are key design principles for the Networks. These principles are detailed below:

Fig 3. Community Health Network design principles

5. What will Community Health Networks deliver?

Community Health Networks will be expected to maintain a population focus within their identified geography**.** They will utilise an outcome framework with process, quality and impact measures and ongoing improvement processes to drive improved care for their population. To deliver on the system wide goals of Networks (as included in Section 3.1) they will be expected to deliver enhanced services as outlined below. There will remain flexibility of how these services will be delivered as they will need to be tailored to the population health needs within the Network.

Responsive services delivered in acute circumstances	Networks will provide timely access to services to support people in the community as their health needs escalate. New pathways to support Māori, Pacific and other vulnerable populations will be implemented. The co-ordination and clinical oversight would be expected to be led by members of the Health Care Home teams.
Co-ordinated and centralised proactive care planning	Networks will identify people who are identified as higher risk of admission and enable a care team from across the Network to develop a proactive care plan with patient centred goals. This would include a focus on including Māori and Pacific people with multiple long term conditions.
Care around the clock.	Networks will develop processes and pathways to better manage Māori, Pacific and other vulnerable populations people in the community for as long as possible. Developments between the Health Care Home practices, after-hours services, District Nurses and Allied Health practitioners are likely to be required.
Specialist consultation services reach more people	Specialist teams within the Network will participate in providing their expertise through new approaches instead of traditional outpatient consultations or during admission eg. virtual advice, multidisciplinary care planning. Services that support the needs of Māori and Pacific people will be prioritised to be part of the networks.
Streamlined referrals and access	Referral process within Networks could be refined, or even removed as Network services work in partnership. A co-ordinator within the Health Care Homes will utilise the electronic Shared Care Planning tool to liaise communicate and manage the delivery of relevant tasks around a patient for acute and planned care.
Active support at the transition of care	Networks will establish pathways and service linkages to support people to be transitioned back to the community as soon as possible after an admission and/or presentation to the emergency department. Linkages with Pacific and Māori support services will be a key enabler within the Networks.
Skill sharing and development	Clinical expertise skill sharing between services in the Networks will enable the expansion of the Health Care Home team roles as providers of more complex care (eg. wound management, IV therapy, insulin initiation) and specialists to gain a better understanding of capability of primary care. This may progress to some of the Health Care Home teams that have highly developed skills in certain areas to also provide support, via horizontal referrals, to other practices in the Network.

6. Where will the CCDHB Community Health Networks be established?

The CCDHB Community Health Networks will be based around geographical groups of people in the community as follows:

People have been grouped into Networks based on demographics, health need and physical proximity. It is acknowledged that this broad groupings do not represent a homogeneous population, but provides identify people with similar needs and allow for practical grouping of services in geographies.

The Network population groupings while established will be flexible particularly through the implementation planning stages. Further consultation and analysis may require some adjustments to the Network groupings.

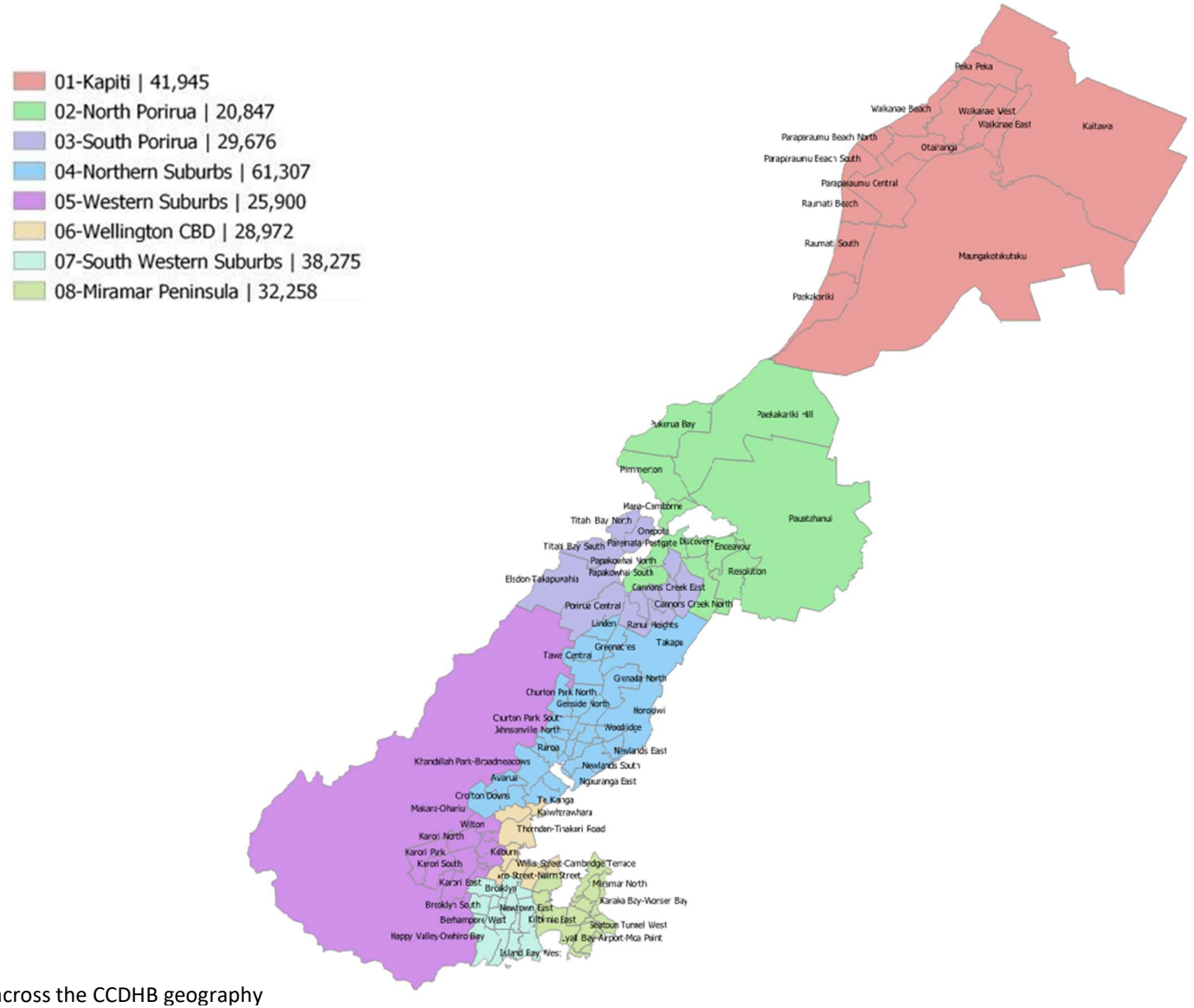
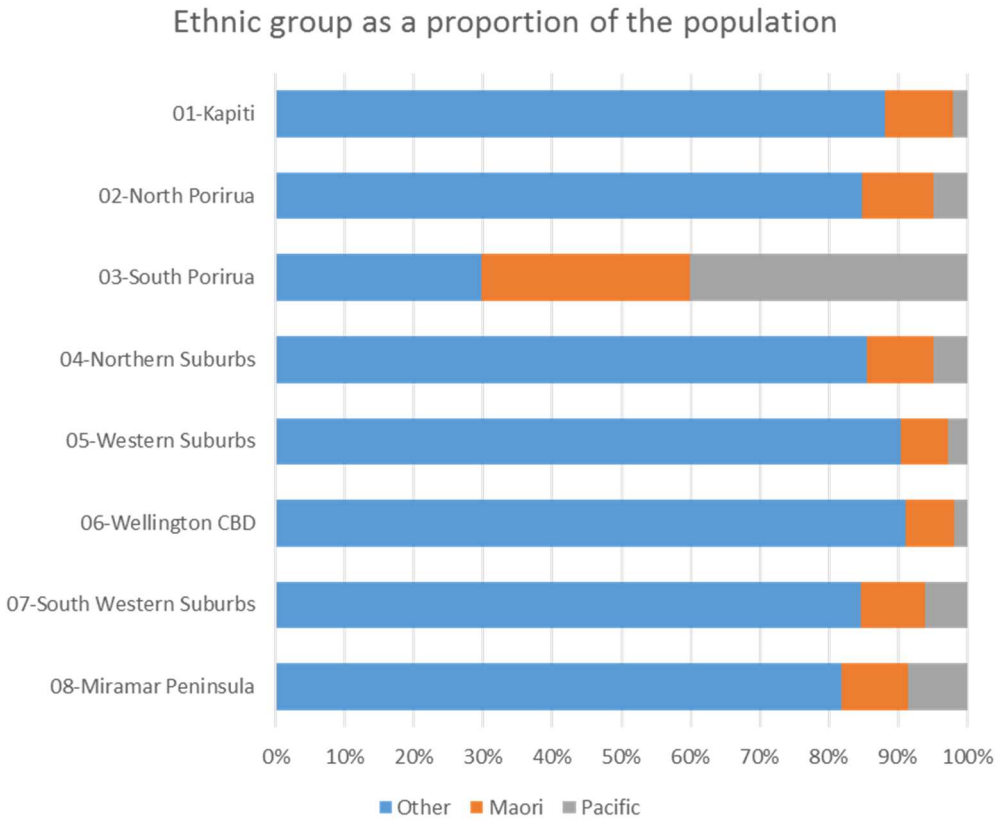


Fig 4. Community Health Networks across the CCDHB geography

The following is a summary of the population profile of each of the Networks:

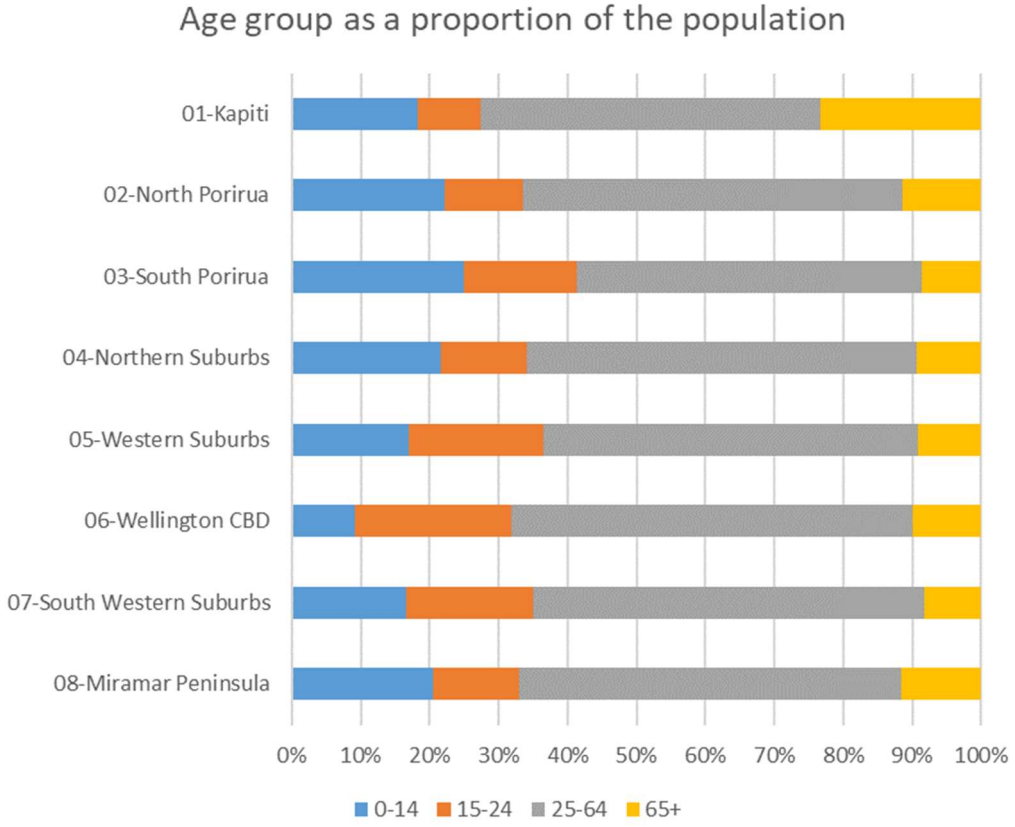


South Porirua has the largest proportion of Maori and Pacific people

Most Networks have by far, higher proportions of "other" populations

Miramar Peninsula has the second highest proportion of Maori and Pacific people

Graph 1: Community Health Networks ethnicity



Kapiti has the highest population aged 65 years and over

South Porirua has the highest proportion of children and youths

Wellington CBD has high proportion of 15-24 year olds.

Graph 2: Community Health Networks age groups

7. What services will be included in Community Health Networks?

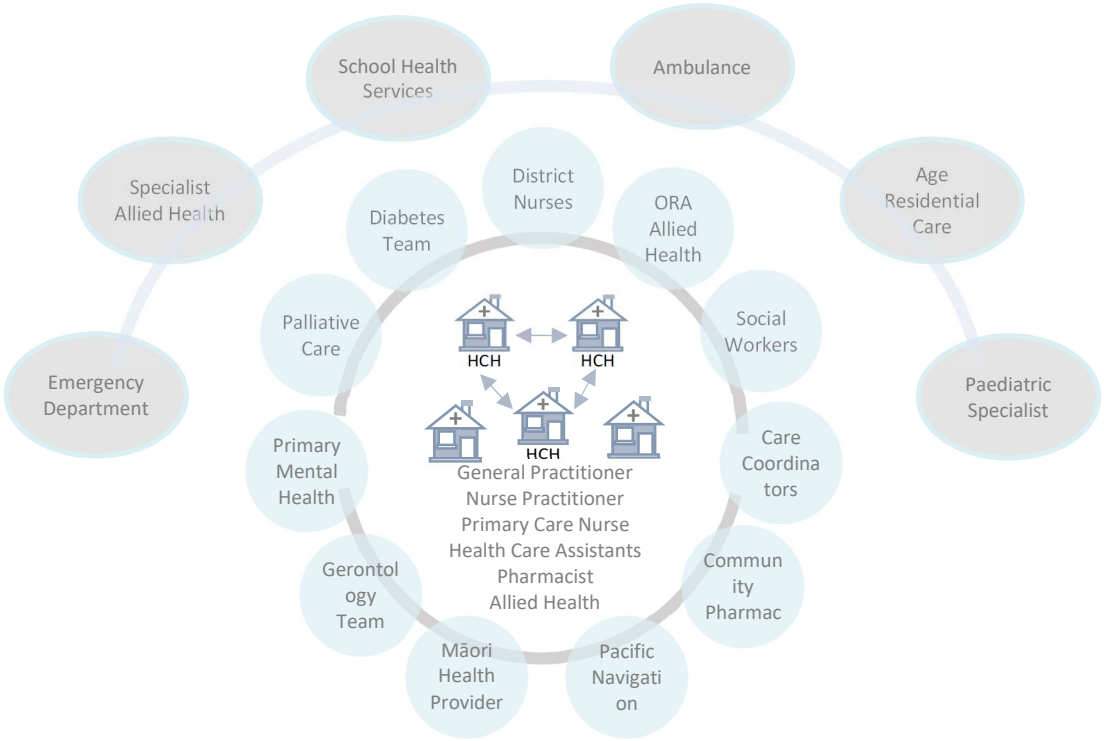


Fig 5. Services organised as a Community Health Network

Each Community Health Network, as described in Section 6, includes a population with different health needs. As a consequence each Network will include service that meet the needs of the population. There are some services that are likely to be beneficial to most of the Networks (the first circle of integration), and there are others that will be included based on more specific population health needs (the second circle of integration). While the linkages will be established across these services, their involvement in individuals care will vary over time based on their need as demonstrated below:

As care needs change, the Care Team gains additional members. It is not a different team.

7.1. Health Care Homes – the core of Community Health Networks

Fig 6. The Network will maintain the person in the centre. People will be wrapped with support first through their primary care team, and in many cases a Health Care Home. Primary care will be the key service to co-ordinate the changing service support needs across the Network for a person.

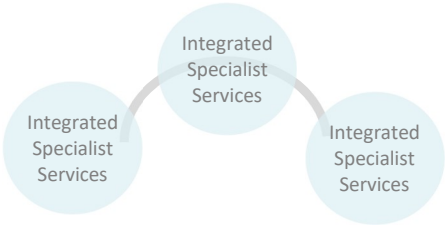
The diagram has been adapted from The Person Centred Health System and the Medical Home. Australian Centre for the Medical Home. Accessed via http://medicalhome.org.au/the-person-centred-health-system-and-the-medical-home/ on 17th May 2016.

General Practitioner
Nurse Practitioner
Primary Care Nurse
Health Care Assistants
Pharmacist
Allied Health

Primary care services are known to be effective partners with people to manage most of their care. Health Care Home practices are delivering even better primary care in CCDHB and will form the core services in the Networks. There will be a group of Health Care Home practices, and potentially other primary care practices in each Network. It is expected peoples key contact for health services will be via the primary care practices.

The practice team membership will evolve over time as workforce development is progressed and roles move to working at the top of their scope. There will be a member of each of the primary care practice teams that will be identified as care coordinators. Their role will be to manage the changes to a person's care team from the services in the Network based on the changing needs for a person. This would for proactive, acute and preventative care planning. It will include increasing as well as reducing the number of Network services involved in the patients care as their needs change.

7.2. Specialist Services Integrated as the first circles of care Community Health Network



The first circle of integrated services are those that are like to be aligned with all Networks. The first specialist services to be linked into all Community Health Network are likely to be ones that maximise the benefits to the population and health system, as well as have developments underway moving them closer to the community.

The following is a summary of services that are likely to be in the first circle of care:

District Nurses and Community Allied Health teams are connected with Health Care Homes through the existing community service development. There is an identified District Nurse and Allied Health practitioner aligned with each Health Care Home and they will provide the first point of contact for their services, participate in regular proactive care planning meetings and in the future share skills with the practice team that would be beneficial for the population. Case Managers from **Care Co-ordination** and **Palliative Care** have also been partnered with Health Care Homes to participate in proactive care planning meetings for people that would benefit from their input. These existing partnerships with Health Care Homes will be further supported and enhanced through this Network approach. The Network approach will also help to resolve some capacity

issues as the specialist team members could move to work with a wider group of practices that are the core of the Network, rather than individual practices. As the majority of the work delivered by these services are in the community already there may be opportunity to develop a collective community team with members from across these services to work in partnership with primary care teams.

Diabetes specialist services are connected with priority practices through the existing Diabetes Care Improvement Programme. The Diabetes team members, including the Consultants and Diabetes Nurse Specialists, that are associated to the practices provide the first point of contact for diabetes support, participate in long term condition planning, provide training for insulin initiation and titration, and participate in case collaborative conferencing. The relationships between the teams are mature and quality improvement processes continue. These services could be incorporated into the Networks to strengthen the linkage with other teams across the Network.

The **Health of Older People** specialist team are due to start working with key stakeholders to develop a new model of care that focuses on improved care in the community. This would involve the Consultants, Nurse Practitioners and Pharmacist. The actual service model is to be defined and is likely to link Gerontology Specialist services with the Health Care Homes and support proactive and acute care for older people. Similarly, there are developments underway with **Mental Health** services to trial new models of care that support care in the community that are connected with Health Care Homes.

There is a new model of care being developed for **Allied Health** teams that will expand on the existing services and relationships with Health Care Homes, as well as the delivery of innovative care models in the community.

Community Pharmacists and Pharmacy teams are well placed to work closer with primary care to improve medicine related care. The services that they provide can be developed specific to the population within the Networks with a focus on supporting long term conditions.

7.3. Specialist Services linked to Community Health Networks

There will be a number of additional specialists teams, from the hospital and other support services that will be linked into particular Networks only.

These services will be linked into the Network on occasion based on particular peoples and population need and work with partners to support acute care or participate in proactive care planning. The process of linkage with the other services is likely to be bespoke to each Network and may be periodic based on the population health need.

7.4. Community Health Network Prototypes

The Porirua South and Kapiti Networks will be two prototype Community Health Networks in CCDHB that will the first to be developed and include additional services that are specific to their population health need.

The **Porirua South Community Health Network** will focus on mothers, babies, children and youth. This Network includes a higher percentage of high needs populations, younger demographic and have a higher utilisation rate for hospital services. Opportunities within this Network will link with the localities approach that is likely to focus on:

- Mothers and babies
- Children
- Establishing youth health support by building on existing services
- Kenepuru afterhours service access that can be supported in partnership with Health Care Homes

The **Kapiti Community Health Network** will focus on supporting the people to receive more care in the community and reducing their travel from Kapiti. This Network has a population with a higher percentage of older people, lowest rate of self-referral to ED and the highest rate of ED admission. Opportunities within this Network will link with the localities approach and will include:

- Specialist video conferencing as an alternative to some outpatient appointments
- Kapiti afterhours service access that can be supported in partnership with Health Care Homes
- Transport destination options by ambulance within Kapiti

8. What infrastructure is required for Community Health Networks?

8.1. Governance and Shared Goals

Community Health Networks will be supported by a collaborative governance group to drive improvements in population health outcomes for the people enrolled within the Network. The Governance Group will be responsible for:

- Establishing an outcome framework for their network as a tool to ensure improvements in the four domains of health are a focus
- Regular monitoring, reflection and development of improvement processes that would drive further improvements in agreed outcomes.
- Clinical audit and adverse event management
- Driving discussion between services to support the maintenance of effective working relationships, identify further synergies and develop local innovations
- Quarterly updates to the Integrated Care Collaborative Alliance Leadership Team about key progress, issues and opportunities
- Making recommendations through to the Integrated Care Collaborative Alliance Leadership Team for service improvements that would require significant changes to services and/or additional resources.

As Networks mature, there is a potential to establish improvement goals and introduce incentives for improvements. The Governance Group would be responsible for driving these improvements.

The governance groups will include a member from the Health Care Homes, linked specialist services, relevant PHO members and Strategy, Innovation and Performance and a representative from the community. Each member will be a representative of their service. A Chair would be elected from within the group and will be supported with a Network Support Team (see 6.2).

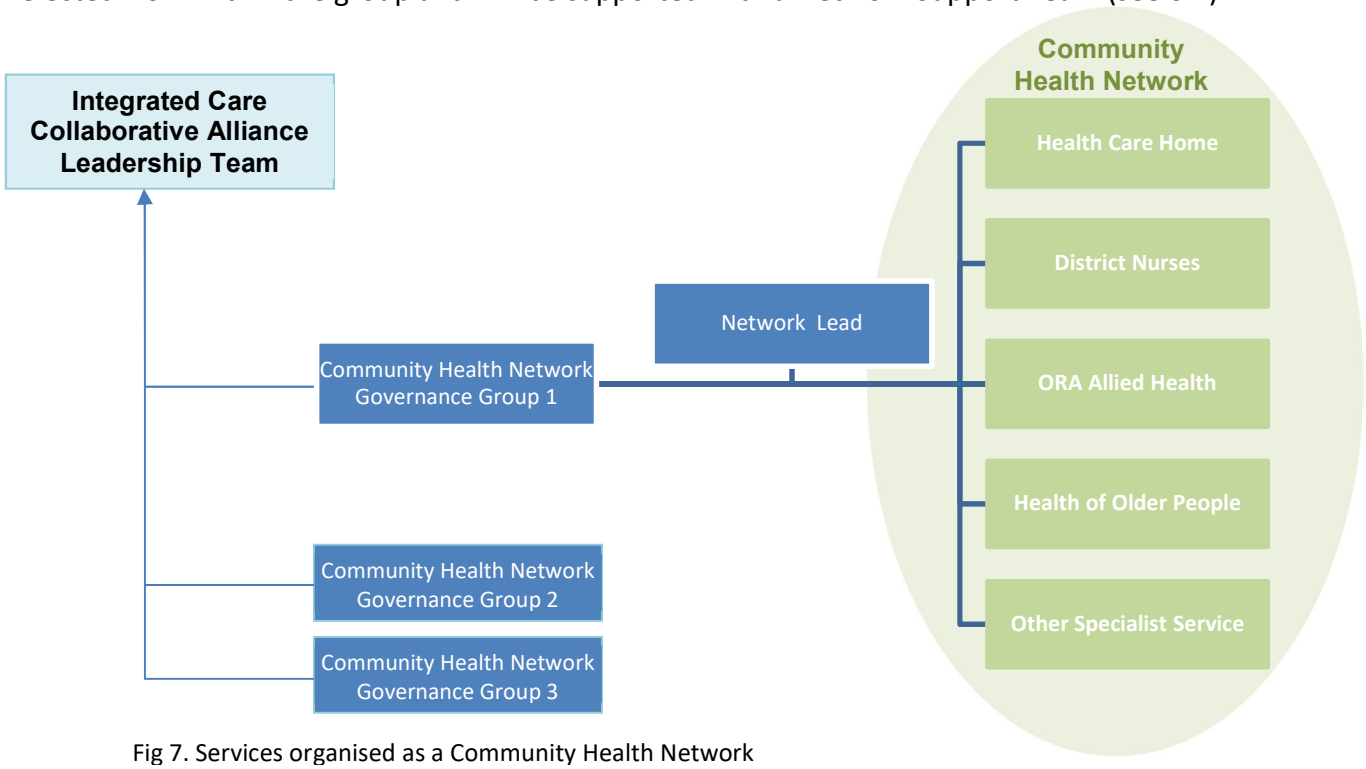


Fig 7. Services organised as a Community Health Network

8.2. Management & Support

Each Community Health Network will be supported by a Network Lead who will be responsible for the operational establishment and maintenance of the Network.

In the first instance, there will be a team of Network Leads established that will develop specific implementation plans for each Network. This will require significant focus on establishing relationships with future Network members, developing a shared understandings of Community Health Networks and plan specific milestones that will be tailored to each Network.

Once the Community Health Network is established, the Network Lead will be responsible for:

- Establishing the required cross-organisation charter/agreements to drive members of the Network to work together to drive collective improvements for the enrolled population
- Maintain contact and service information across the Network
- Providing support to people within the services to work through operational issues. This will include maintain a linkage with the services existing management structures and personnel.
- Providing operational support for the Governance Group to delivery on its activities. This would include the running of meetings, managing quality improvement processes and delivering comprehensive data and analysis.
- Collaborating with other leads to support ongoing process improvements.

As Networks mature and the relationships and shared responsibilities between the services mature there is likely to require changes in management and support. The role of the Network Lead and the agreements between services will be strengthened to further support care in the community.

8.3. Tools and enablers are required for an effective Community Health Network

For Community Health Networks to reach their potential they will need to be supported with a number of enablers. The services must be able to connect and collaborate with each other, as well as deliver care in flexible settings across the community. The services in the Networks will also need to be supported with clinical tools to streamline care amongst the various services. In acute situations the services will need access to resources to support people in the community during episodes of higher health need.

There are a number of enablers in place or in development that will support the Networks:

- Electronic access to comprehensive patient information and care planning will be essential between Network members. These developments are underway and should be available as Networks are established.
- A new E- referral system is being scoped and will enable services to be accessed as required for patient care.
- Mobile devices are available for many hospital services working in the community and there is a programme underway to expand access.
- Health Pathways provide guidance on the best practice management of conditions, including referral criteria. The programme is well established and is likely to be expanded.
- The current Primary Options for Acute Care service provides resource to Health Care Homes and practices to deliver enhanced services to prevent acute presentations for certain conditions.

- Community access to radiology is available and work is being planned to further enhance this service to enable more investigations to be completed in the community. This would support both acute care and planned care in the community.

There are a number of enablers that are likely to require scoping and implementation as Networks are developed:

- Expansion of Primary Options for Acute Care with a rapid response nursing team would be a key tool that the Networks could utilise to support a wider range of people during higher health need in the community. In the future this could be further supported with the respite beds as an alternative to admission to the hospital.
- Virtual advice from specialists is being delivered electronically on request by a number of services and there are trials underway for video based consultations. Both aspects of virtual care could be expanded across the number of services delivering these services by improving the processes that support the delivery of these services.
- A scheduling and tracking tool to support service deployment within and across the Networks will be required. This will be key not only for individual services to ensure they are delivering the right care in the right place, but also for the Network as a collective to ensure there are efficiencies in care provision across a range of services.
- The ability to directly book services would complement the e-referral development underway. In the first instance this may focus on service and people in the community managing bookings with a specialist service. As referrals between other services in the Network are expanded (eg. horizontal referral) improved bookings with Health Care Homes would be beneficial.
- Common assessment processes across services will consolidate assessment processes and reduce duplicated efforts. With the expansion of the teams involved in a person's care, there is a risk of even more assessments to be completed. It would be beneficial for a common assessment form to be completed, that would be added to by various specialities as required.
- A capacity planning tool to analyse and subsequently organise services required to support the population with in the Networks.

A complementary work programme for these developments will be required, and could be completed in a number of the workstreams in the Integrated Care Collaborative.