NP-Mātanga Tapuhi
Community Older Persons Service

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NP –Mātanga Taphuhi

NP Community Older Persons service

Background

Nurse practitioner, specialist area of Older Persons Health

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Aims :

- strengthen the capacity of primary care by providing expert clinical nursing and advanced gerontology assessment to older people with highly complex health and social needs.
- Provide education and training of nurses in gerontology
- Advice to primary and community services

Integration

Integration in healthcare is a multifaceted approach aimed at connecting services, providers, and sectors to deliver coordinated, continuous, and patient-centered care, with the ultimate goal of improving health outcomes, efficiency, and patient experience.

Goodwin, (2016)

Horizontal integration.

Integrated care between health services, social services and other care providers supporting older people

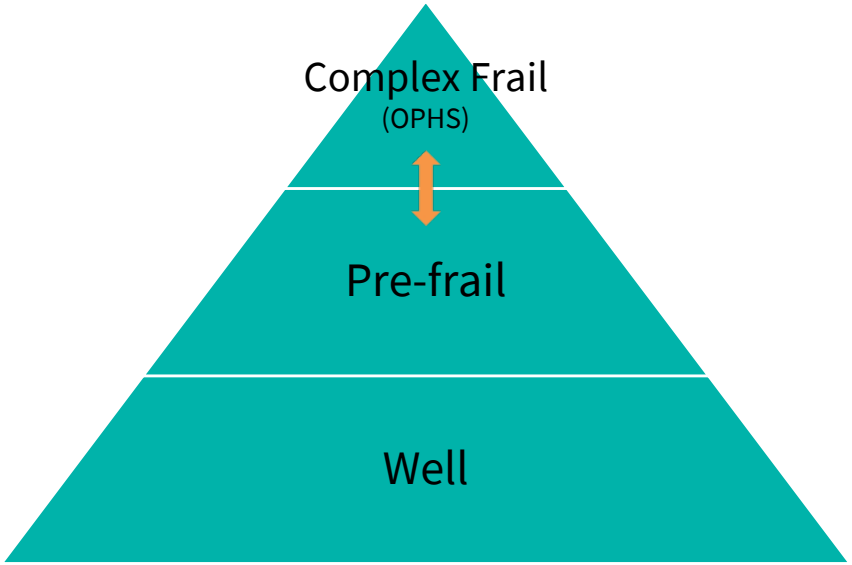
Vertical integration.

Integrated care across primary, community, hospital and tertiary care services

Cumming et al. (2021)

Where does NP-Community Older Persons service fit within existing services?

- Works with GP team and alongside OPHS to deliver collaborative and co-ordinated care
- NP = ↕



- Usually time limited but will case manage a few

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Health Pathways Referral guidance

- do not meet secondary care requirements.
- do meet secondary care requirements but need additional support to engage with services.
- do not fit neatly into established services and may benefit from early intervention.

Exclusions include patients:

- already referred to Community Nursing.
- who live outside the Christchurch city boundaries. Potential to benefit from early assessment and restorative approach
- Excludes those living in residential care

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Common reasons for referral

Cognitive impairment (75-80% of referrals)

Frequent presentations to hospital/acute services

Frequent engagement with emergency services eg St John ambulance callouts

Difficulty engaging in healthcare services

Frequent falls

Social concerns/social frailty

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Integrated care

Three overlapping groups of patients have been identified in the literature who may experience the greatest benefit from integrated care:

- multimorbid patients with two or more chronic diseases (for example, in the management of diabetes, hypertension, and ischaemic heart disease)
- patients with moderate or severe mental health conditions and
- Elderly people

Maruthappu et al. (2015).

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How it works

Home visits to frail and pre-frail older people 65+ and Māori and Pasifika 50+

- Mild to moderately frail (CFS 4-6)
- Complex care/multi morbidity eg existing cognitive impairment or new dementia diagnosis plus multiple co-existing health issues (Diabetes, COPD, CHF, depression, arthritis)
- Often people live alone, few or fragile natural supports, social vulnerability
- Comprehensive history and engagement with whanau, physical examination, arrange any tests ie exclude other causes of cognitive changes, make and discuss diagnosis, develop a care plan and engage supports, provide education for patients and families
- Follow up of care plan –generally 3-5 visits over several months and case manage a few over a short period

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NP scope

Enables consideration wide range of issues/concerns (from Nursing lens) for the person to live well at home

- new diagnoses and treatments plans, medical management and medication reviews
- home safety concerns, driving
- nutrition, personal care
- vision/hearing
- shopping, social networks, and linkage with Dementia specific and
- govt funded services ie disability allowance.
- Environment/ housing/equipment/level of care
- Legal: EPOA/Welfare guardianship/ advanced care planning/Shared care plans

Poghosyan et al (2021)

Engagement with primary and secondary care services

General practice teams and nurses

- GP's/NP's/Practice nurses
- HIP's/health coach
- Pharmacists
- Community services providers: district nursing, community services
- Acute demand – short term nursing management for acute issues

Primary and secondary care linkage

- Older Persons Health specialty services
    - clinical assessors for InterRai, carer support, physio, OT, social worker, Memory clinic, specialist psycho-geriatrician advice, CREST – rehab at home
- Hospital services
    - transitional care post discharge
    - Secondary care specialists ie Diabetes, cardiology, palliative care, oncology;

Engagement with services and initiatives in the community “the glue

Dementia mate wareware specific services

- Dementia Canterbury
- Cognitive stimulation
- Dementia support workers
- Exercise groups
- Medical alarms, wander tracker

Wider community groups to support the person with Dementia

- Knowledge of local community support services ie local library services, community centes and groups,
- Age concern services ie volunteer visitors, social engagement, transport assistance
- Māori and Pasifica whauau ora and nursing services
- Presbyterian support services, homeshare groups
- WINZ/local government/fire service

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Enablers and learnings

- Good relationships, establishing support and connectedness across the local community and health sector – knowing the community well
- Wide knowledge of health system and local services
- OPHSS Interdisciplinary team and complex case meetings
- shared electronic health record -Healthone/Health connect South
- Shared care planning – acute and personalised care plans, advanced care plans
- Co-location in PHO
- Care co-ordinators in primary care
- Flexible time, Home visits
- Nursing scope/philosophy of care

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Benefits/outcomes

- NP's with expertise in Dementia diagnosis and care can independently manage the whole process or co-manage with the GP/NP in primary care
- Flexible and nimble – can often respond quickly BUT not an acute service.
- Improved access for those who maybe anxious about engagement with health services
- Improved co –ordination and engagement with services for the PWD and their whanau
- Gerontology nursing expertise closer to primary care supports general practice teams
- Proactive planning to avoid crises
- Reduce time to entry to ARC

References

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Case example

80 year old European woman

T2 Diabetes on insulin; severe OSA on BIPAP, CVD/CHF, OA

Lives alone In community housing complex

Complex social issues – family discord, socially isolated

Indep with personal care, safety concerns, not driving

History and collateral sons x 2, practice nurse, pharmacy

PE, MACE, blood tests, CT head scan

- New diagnosis Dementia
- Planning with patient and family/whanau
- Strengthened links with GP team and secondary care for medical issues to be addressed
- Engaged with Dementia support services
- Home based supports - engaged with OPHSS longterm support team and wider community supports
- Discussed EPOA and ACP