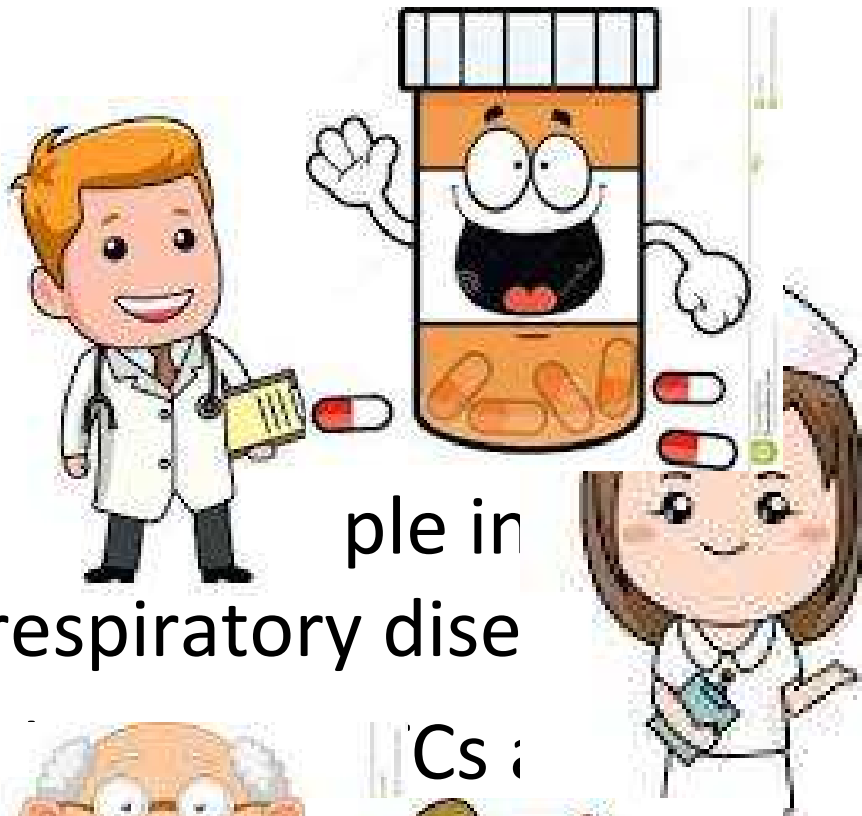




An integrated approach to long term condition management

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Activated patient + activated clinician



Understand their condition
Are comfortable with the way their care team supports them
Feel in control of their condition

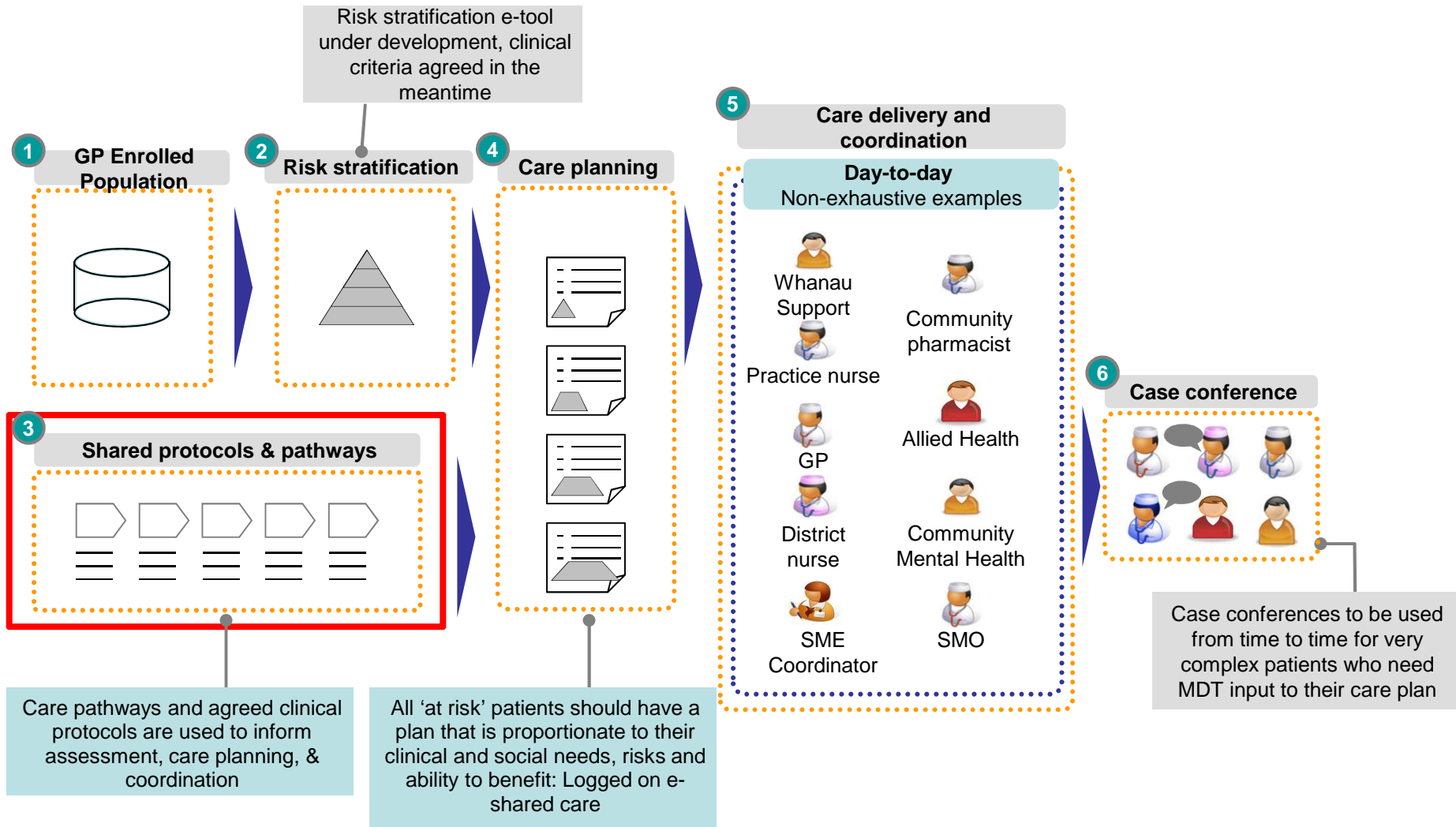
Support patients to set goals and work towards them
Co-ordinate care
Facilitate sharing of information with care team



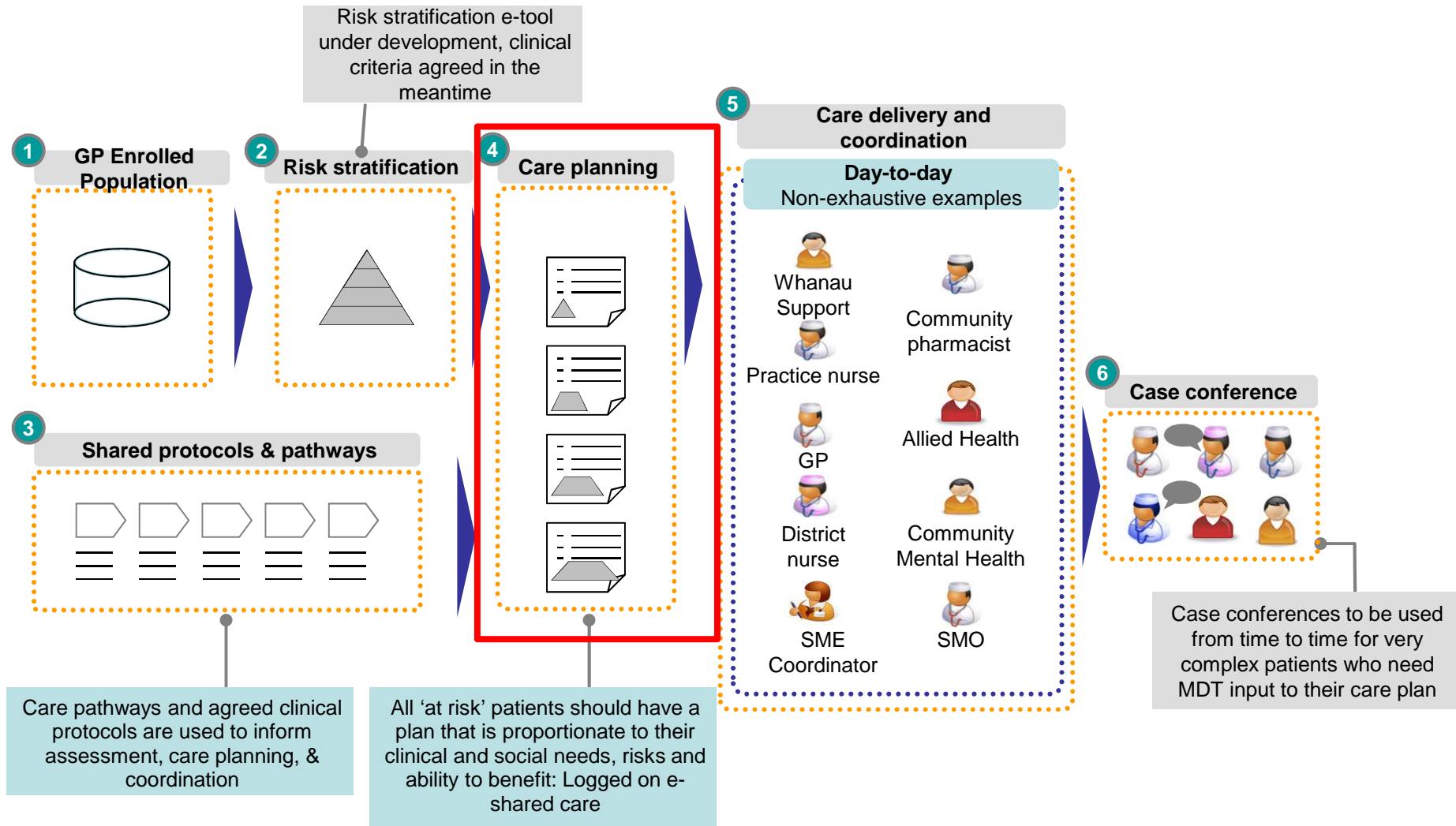
At Risk Individual

- Enhance capability & capacity of PHC Home
- Proactive, planned primary care
- Named care coordinator in existing PHC home
- eHealth summary & eCare plan tools
- Access to multidisciplinary teams (MDT)
- Complex patients
 - Multiple diseases
 - Mental health problems
 - Social issues

Proactive Planned Care



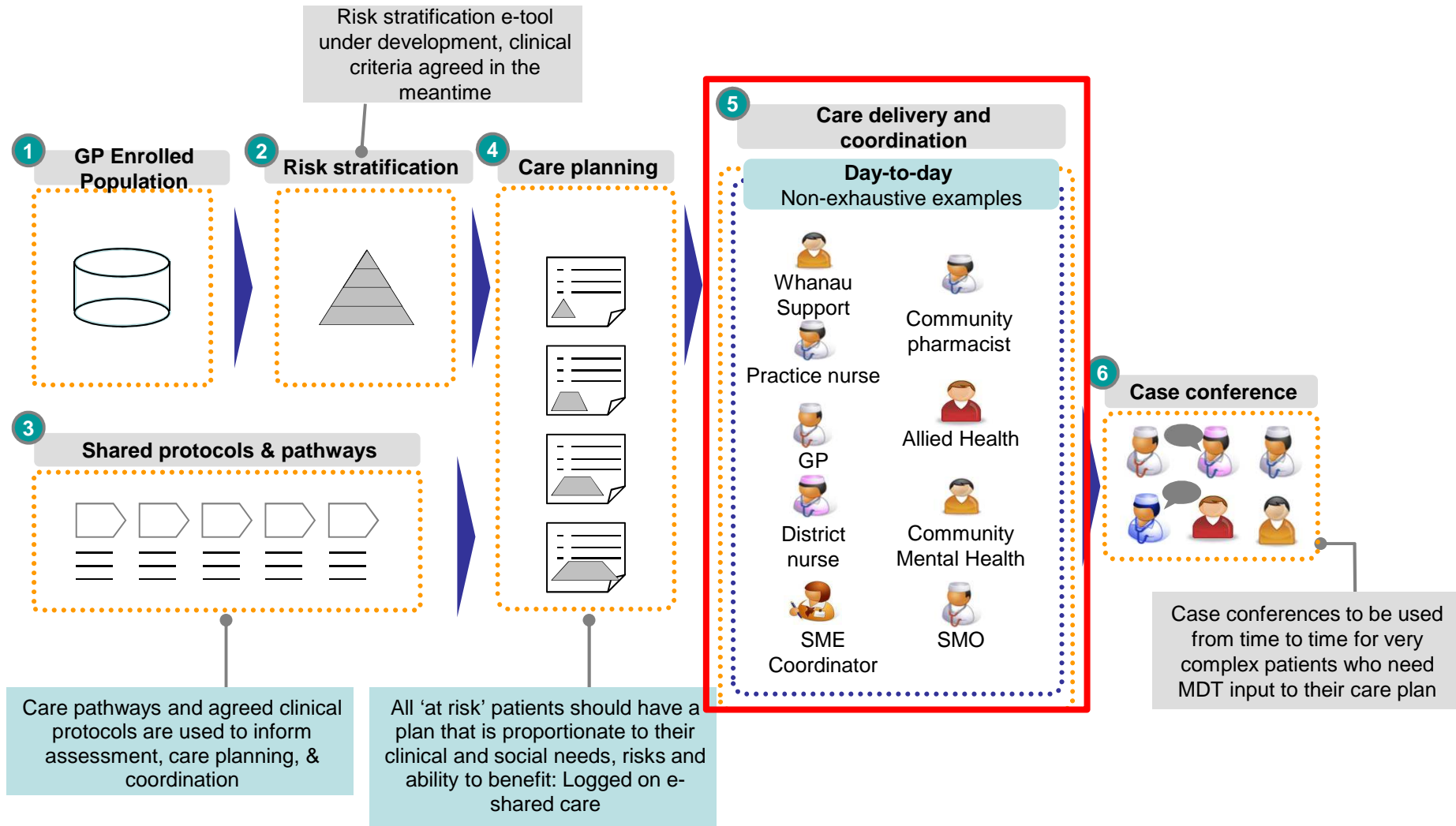
Proactive Planned Care



Care plan

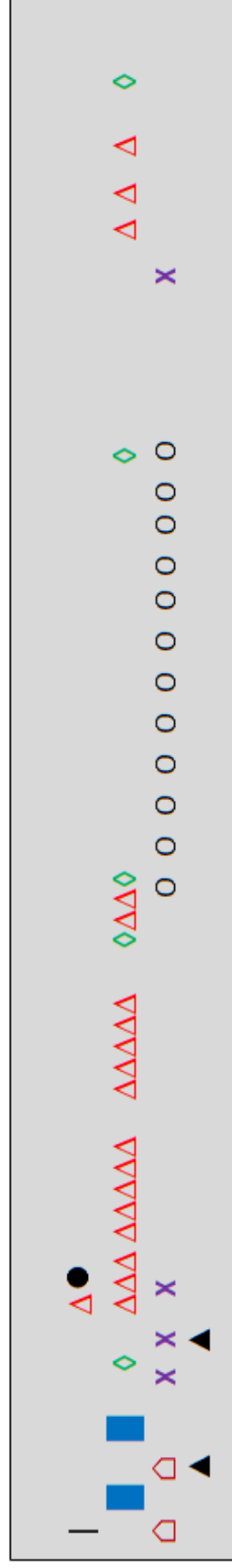
| | | |
|--|--|---|
| Heading: My Goal | | + |
| Action: Main priorities | | Matua has a number of things going on right now so we will start small 1st is understanding his medications & condition (gout). 2nd any additional support we can offer for his alcohol addiction. |
| Action: To give up drinking | | Mack has had a long battle with alcohol, and has been in rehab previously. He is still working towards being alcohol free. |
| Heading: About Me: | | + |
| Action: My life | | Speaking with Matua today he says his wife has recently come out of jail after 2 1/2 years. Family life has been disrupted and Matua's drinking has increased - he has support from Raukura regarding counselling and support with his drinking. |
| Heading: Things I Will Do | | + |
| Action: Matua's Role | | Matua agreed to come see me again in 1/12 to catch up on how things are going Any changes? |
| Action: Contact Terry Taniwha (Counsellor) when I feel stressed | | Mack is connected to Raukura addiction services, 021894271 and he has recently completed an 8 week programme for community rehab. He has a good relationship with Terry, and has been asked to consider residential rehab. |
| Heading: Things My Care Team Will Do | | + |
| Action: GP & Nurse | | I (Racheal) will draw up a medication chart for Matua - refer to aswell as highlighting key points of how to recognise a flare up and prevention. Get in contact with Raukura - see what we can do to support Matua. I will also f/u with Matua in a month to see how he is going with Etoh management. |

Proactive Planned Care



ARI Patient Journey

(63 yr Maori male with heart failure)



July 2014

March 2015

Key

- Clinic DNA
- MMH Inpatient Admission
- ▲ NASC review and coordination
- × MMH Outpatient Clinic
- ◇ Nurse F/U Phone
- △ GP Practice Visit
- ARI Programme enrolment
- Healthy hearts exercise prog

Regional ARI pathway

<http://www.healthpointpathways.co.nz/northern/a-z/at-risk-patients/>

Clinical Pathways powered by *healthpoint*

Northern Region

Filter by keyword...

A-Z

- At Risk Individuals
- Cardiac
- Cellulitis
- Chronic Kidney Disease (CKD)
- Cognitive Impairment
- Community Acquired Pneumonia
- COPD
- Deep Vein Thrombosis (DVT)
- Depression
- Diabetes - Type 2
- Dyspepsia/Heartburn
- Eczema
- Febrile Illness Management - Paediatric
- Gastroenteritis - Paediatric
- Gout
- Hepatitis

COUNTIES MANUKAU CLINICAL PATHWAY FOR AT RISK INDIVIDUALS (ARI)
PENDING METRO AUCKLAND REGION SIGN OFF (28TH AUG)

Identify patients at risk ⁱ¹

Assess patient's risk and amenability ⁱ²

Does patient give consent to intervention? ⁱ⁴

No: Do not use this model of care (may become appropriate at a later stage if circumstances change)

Yes

Feedback

Useful Clinician Links

Principles ⁱ³

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Patient portal



My Shared Care Plan

John Carter
DOB: 01-Jan-1967
ID: AAA116

Logout

Settings

Welcome, John Carter !

Shared Care Overview

Save this link as a favourite in your browser to login to the Shared Care programme patient portal
If you 'Hide this Message' it's possible to unhide it via the settings page in your Patient Portal

[Hide this message](#)

My Tasks

No pending tasks

My Care Team

| Name | Role |
|-------------------------|------------------|
| Ross, Deborah | Care Coordinator |
| Einstein, Albert | Care Team Member |
| coordinator , case | Care Team Member |
| Support health/alliance | Care Team Member |
| Chandar, Vishal | Care Team Member |

[View all 9 care team members](#)

- Overview
- My Tasks
- My Care Team
- My Conditions
- My Care Plan
- My Measurements
- My Resources
- My Messages
- Print My Summary
- Who's Accessed My Record
- Family Member Access

Recent Logins
27-Jan-2014 13:24

My Conditions

| Condition | Onset Date |
|---|------------|
| (E2004) Chronic anxiety (137R) Current smoker | |
| (H34.) Bronchiectasis | |
| (H3...) Chronic obst. always dise ... | |

Please contact your family doctor or nurse if you have any questions regarding your medications.

My Allergies

No allergies

My Measurements

| Date | Type | Value |
|-------------|----------------------------|------------------|
| 26-Mar-2014 | Blood pressure | 120 / 80 mmHg |
| 28-Jun-2013 | Peak Expiratory Flow (PEF) | 124 L/min |
| 28-Jun-2013 | Heart Rate | 92 /min |
| 28-Jun-2013 | Spirometry FEV1 | 49.0 % predicted |
| 28-Jun-2013 | Weight | 68.00 kg |

E-SHARED CARE VIEWS

What changes will we see?

General practice will be identifying At Risk patients and supporting them through:

- A named **care co-ordinator**
 - Key point of contact for care
- Developing a **care plan** with the patient
 - Based on patients goals
 - Shared with care team members
 - Ability for care team and patient to task one another
- **eSummary Health record**
 - Visible to all health care professionals
- **MDTs** for high risk patients
- **Flexible funding** for interventions
- **Staged implementation** from July 2014 to July 2015

SWIFT: Model of Care



S02 - Consumer and
Patient Engagement

- How best to engage patients to access health information
- Can access to information and bookings support improved self-management
- How do patients want to engage with their health information at present?
- Is Social Media a valuable resource to empower patients / consumers in self-health and higher level of engagement with systems and services in a “Health Home” model of care.

SWIFT: Model of Care



S03 - E-health and
changing patient
access

- Will devices, apps, and routine self-monitoring be adopted in CM populations as key technologies for co-management of complex conditions in a coordinated, home-based model of care.
- What aspects of healthcare delivery under current models of care can be made more convenient and more patient-centric with the use of technology?

