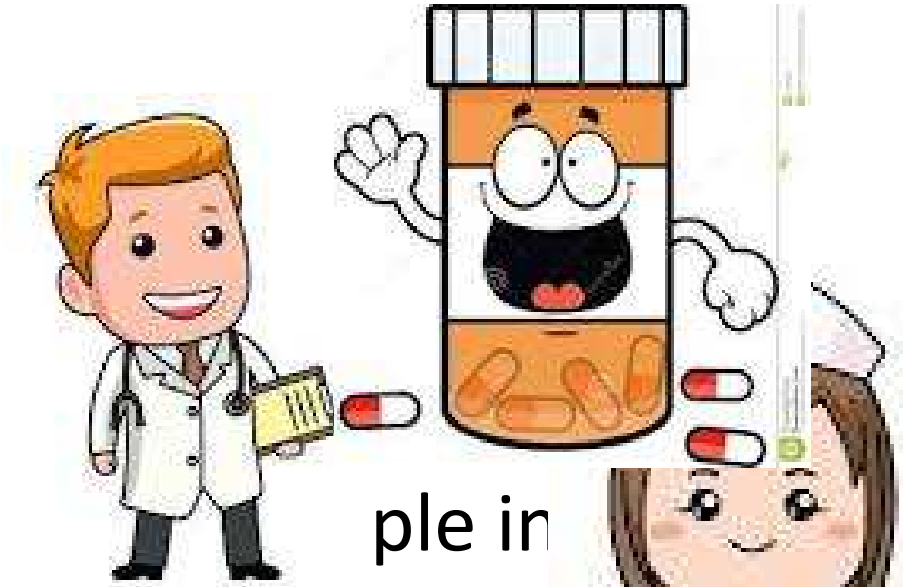
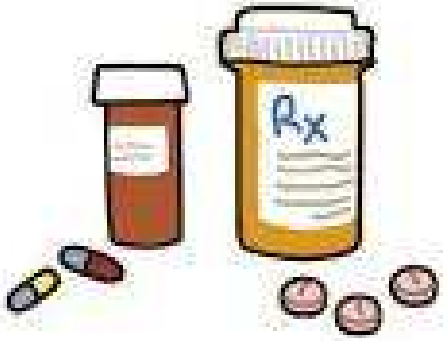
An integrated approach to long term condition management

Date: 31.05.15

Created by: Claire Naumann

- 

e in n in
- ple in 

onic respiratory dise
- Cs a 

ple a 

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

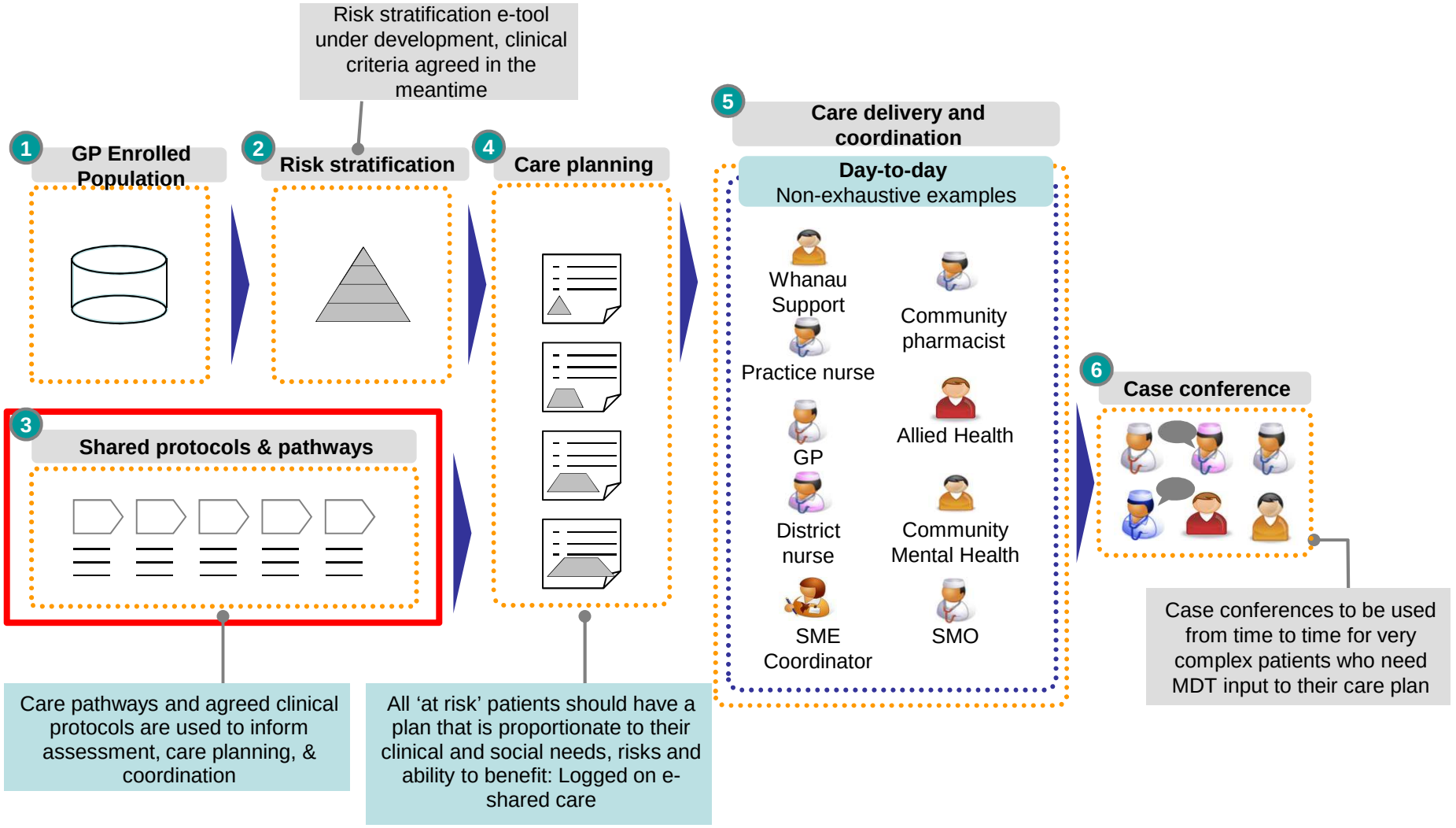
Co-ordinate care

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



PARTNERS IN HEALTH SCALE V10 JUNE 2010

Name: _____ **ID:** ⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋

Assessment Date: / / **Review Date:** / /

Person with Chronic Health Condition to Complete

Please circle the number that most closely fits for you

1 Overall, what I know about my health condition(s) is:

0 1 2 3 4 5 6 7 8

Very little **Something** **A lot**

2 Overall, what I know about the treatment, including medications of my health condition(s) is:

0 1 2 3 4 5 6 7 8

Very little **Something** **A lot**

3 I take medications or carry out the treatments asked by my doctor/health worker:

0 1 2 3 4 5 6 7 8

Never **Sometimes** **Always**

4. I share in decisions made about my health condition(s) with my doctor or health worker:

0 1 2 3 4 5 6 7 8

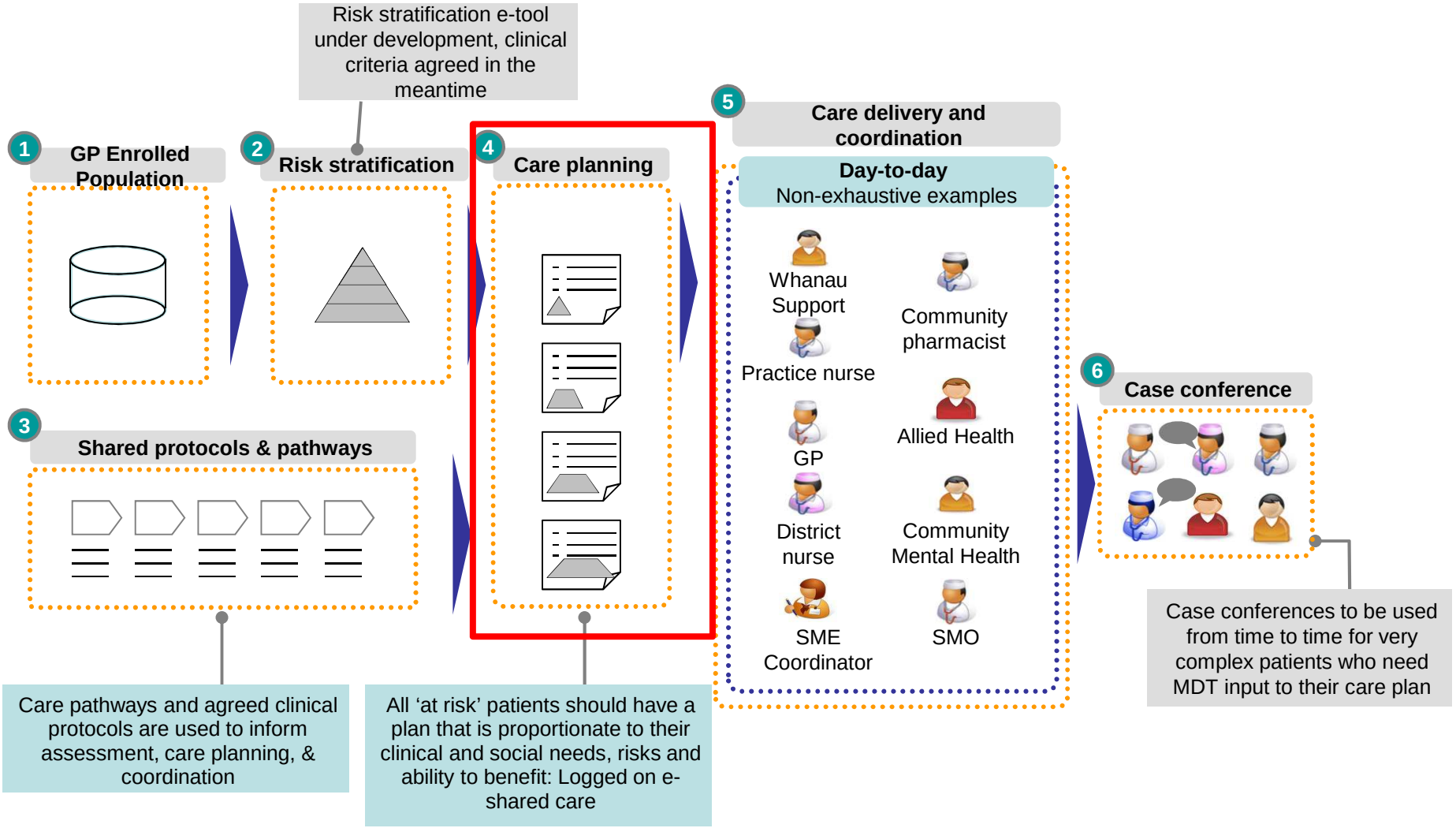
Never **Sometimes** **Always**

5. I am able to deal with health professionals to get the services I need that fit with my culture, values and beliefs:

0 1 2 3 4 5 6 7 8

Never **Sometimes** **Always**

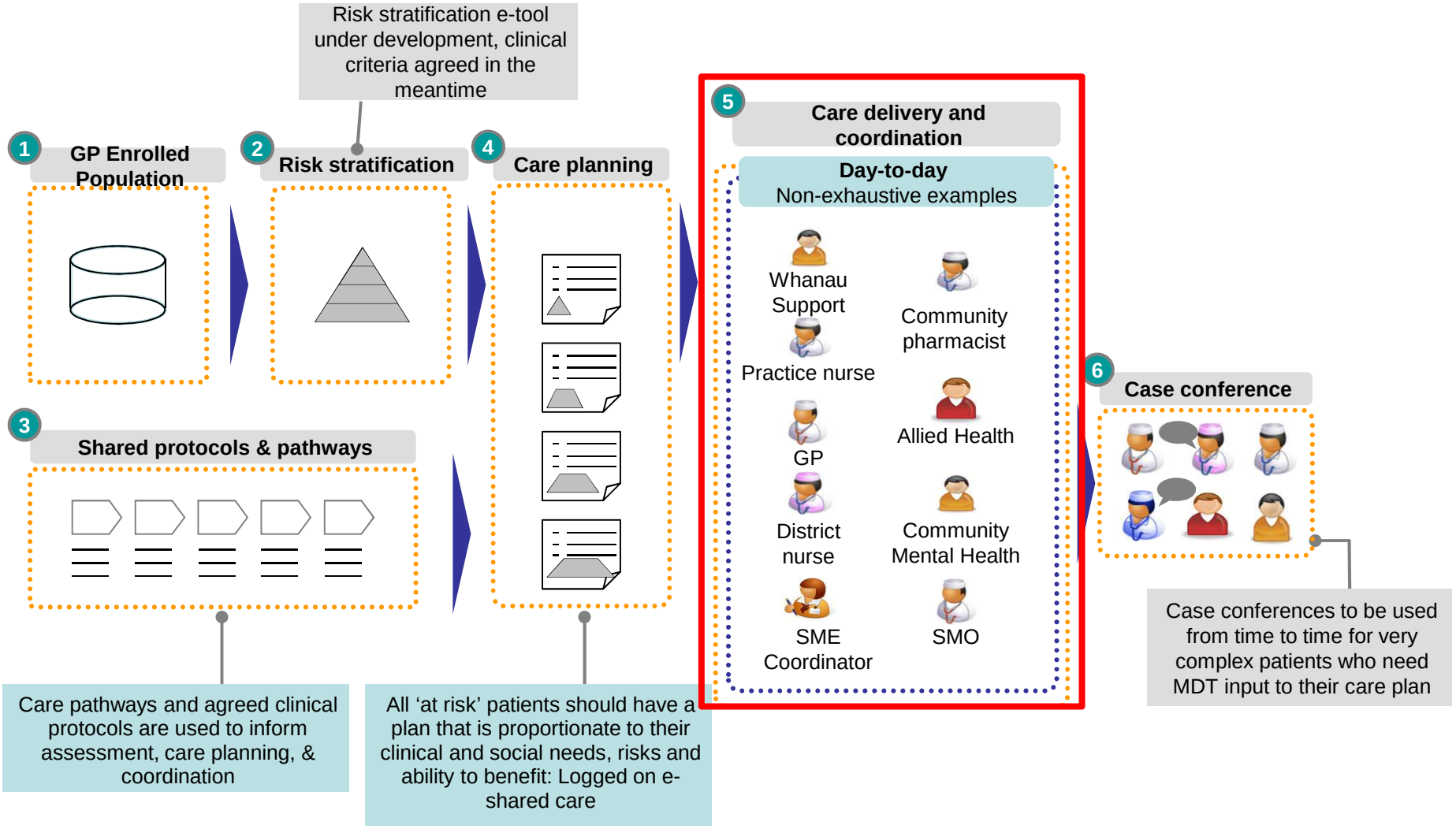
Proactive Planned Care



Care plan

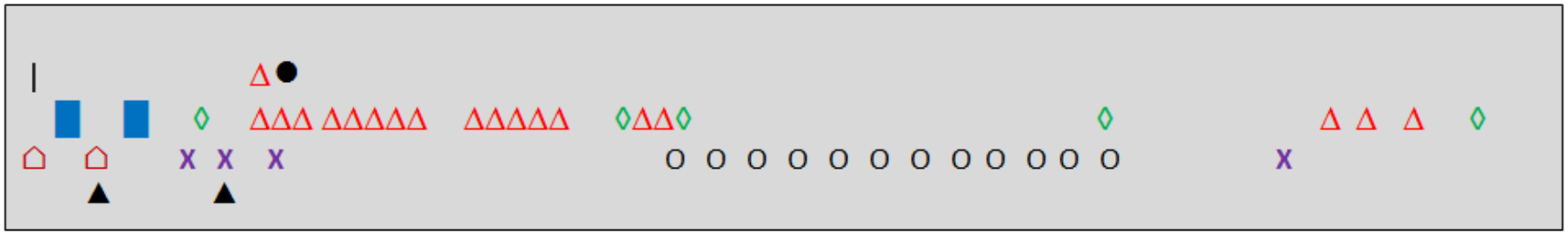
Heading: My Goal	
Action: Main priorities	Matua has a number of things going on right now so we will start small 1st is understanding his medications & condition (gout). 2nd any additional support we can offer for his alcohol addiction.
Action: To give up drinking	Mack has had a long battle with alcohol, 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)



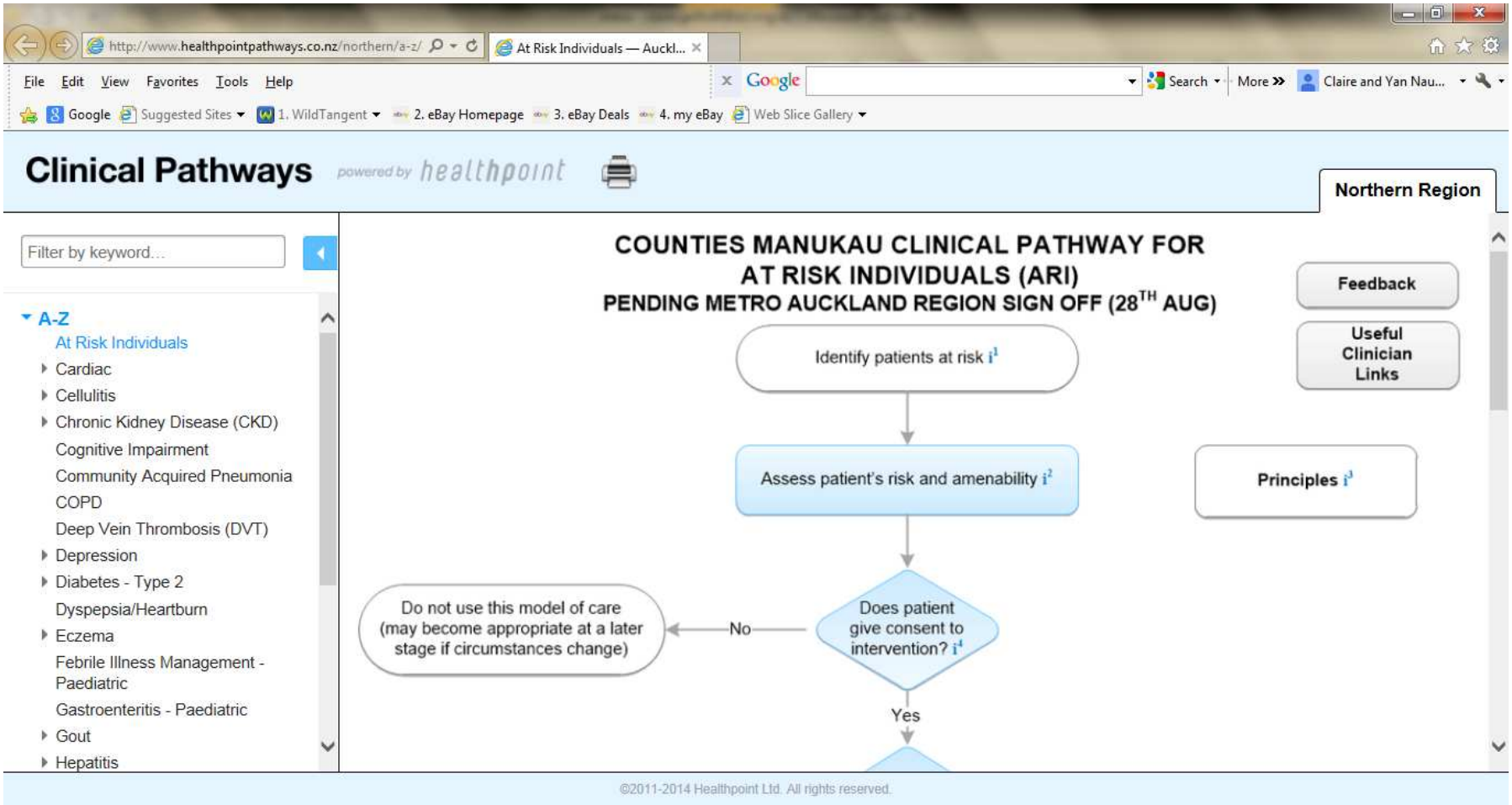
July 2014 March 2015

Key

- ⌂ Clinic DNA
- ▮ MMH Inpatient Admission
- ▲ NASC review and coordination
- X MMH Outpatient Clinic
- ◊ Nurse F/U Phone
- Δ GP Practice Visit
- ● ARI Programme enrolment
- O Healthy hearts exercise prog

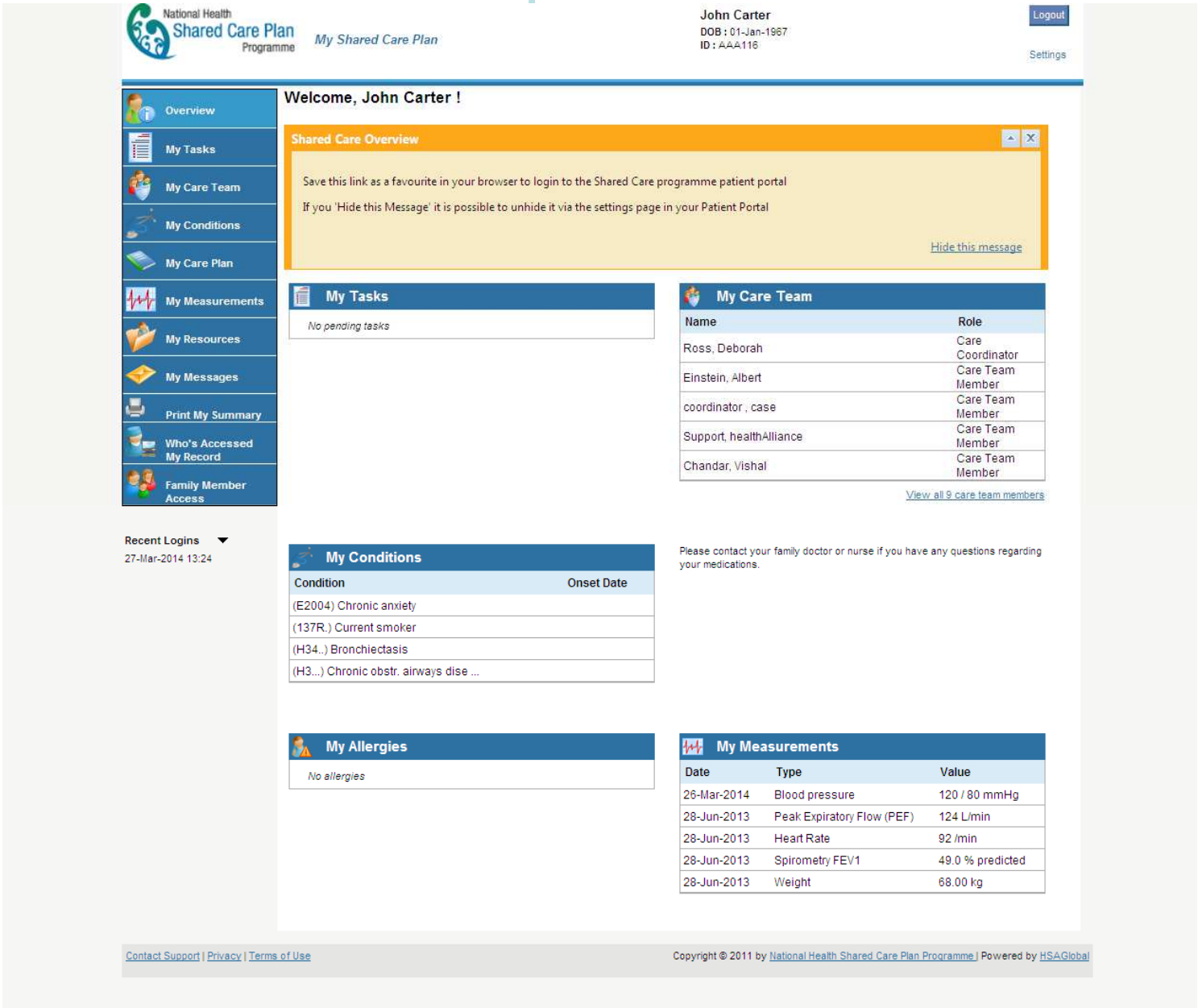
Regional ARI pathway

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



E-SHARED CARE VIEWS

Patient portal



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 implementatio**n 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 deliver under current models of care can be made more convenient and more patient centric with the use of technology?