Technology enabling connected healthcare

CONTEXT

Shared care plans assist patients to manage their own health in collaboration with people involved in their care. They are written or amended by health professionals involved in the patient's care and accessed by providers from across the health system. By supporting a clinical exchange of information, the plans enable the provision of integrated and coordinated care of people with complex health needs, and facilitate greater collaboration across health system providers and between consumers/whānau and their health care team.

The suite of Shared Care Plans give visibility of the patient's perspective and choices in their health care record.

- The Acute Plan has been available in Canterbury since 2016, within the electronic patient record in Health Connect South. Acute Plans support efficient and safe management of patients with complex conditions or who are at moderate to high risk of attending acute services over the next 12 months.
- The Personalised Care Plan has been available since 2018. The purpose of this plan is to document person-centred issues, goals and actions for people who have moderate to high complexity health needs. It is a platform used to document what the patient wants to achieve and how their care team will assist with these goals.

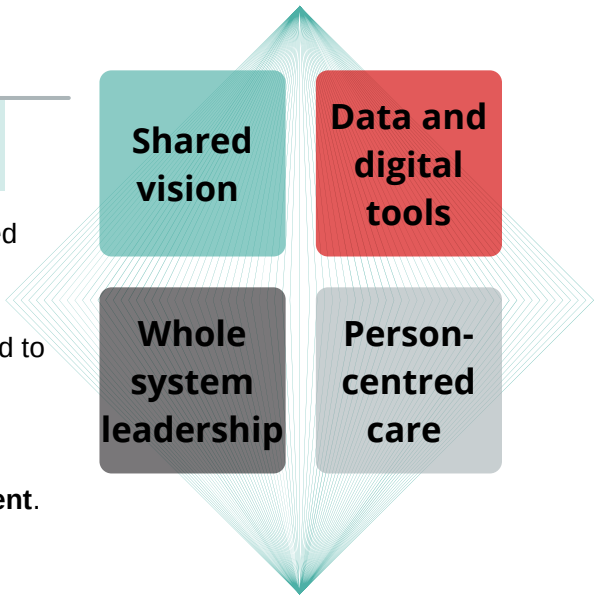
Care planning is a core element of the national Health Care Home model of care maturity matrix, with the characteristics of mature service provision being that the care plans are shared with other wellbeing providers.

Following the success of these plans in Canterbury, they have been adopted across most South Island regions (Southern, West Coast and Nelson/Marlborough). In Canterbury general practice teams are supported to create and amend both of the shared care plans.

PRINCIPLES

The guiding principles which support the Shared Care Plans to succeed are:

- A **clear, shared vision with shared data.**
- **Primary, secondary and community** clinical leadership supported to work together in a **high trust** environment.
- Promoting **person-centred care** by documenting the needs and decisions of our people/ whānau.
- **Clear processes** enabling **collaborative, responsive development**.
- **Regular evaluation and improvement.**



APPLYING THE PRINCIPLES

A clear, shared vision with shared data

- The shared care plan is a tool to capture system-wide input and shared clinical priorities from all members of a care team in one document.
- A data dashboard developed by the Canterbury-based team for the acute plan is shared with all regions, to enable access to daily data feeds on plans that have been created or amended.

Primary, secondary and community clinical leadership supported to work together in a high trust environment

- With health professionals contributing to a single plan, there has to be high trust as some of their information may be amended by others. Providers are responsible for amending the plans to ensure the information is kept up to date.

Person-centred care documenting the needs and decisions of our people/ whānau

- Clinicians are encouraged to make plans with the person/whānau; exploring their needs and perspectives, capturing their voice in the clinical record and placing them at the centre of their own care.

Clear processes enabling collaborative, responsive development

- Regional quality groups were established by the Canterbury Shared Care Plan team. These South Island groups have agreed clear processes around making and agreeing functional improvements to the plans that are then translated into changes to the IT platform. These groups enable the development of the tool to happen in a streamlined way.
- The regional quality groups provide a platform for collaborative design and refinement of both plans.

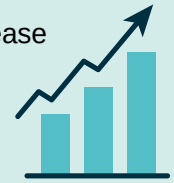
Quality improvement

- Regular auditing processes for both plans are in place and the quality of all plans are monitored through the regional quality groups. This ensures a quality of the plans is consistent across services and regions.

ACHIEVEMENTS AND OUTCOMES

The acute plan was a critical tool used by general practice through the Covid-19 lockdown in 2020 to proactively care for their vulnerable patients.

There was a 400% increase in plans created system wide, with a mix of contributors.



Clinicians reported that they were familiar with the plan and felt confident that it is an effective communication tool that could be used in pandemic scenarios.

> Often we don't have a holistic view of the patient, so the general practice team input is really great, as it gives us background so we can tailor our approach. I think patients genuinely have a positive outcome from using these plans. It speeds up the process, so they get cared for quickly and if they're likely to get admitted, that process is faster."
>
> - ED consultant

LESSONS

- Process - clear processes are needed at the start of the rollout to ensure plans are used in a consistent manner across the system, that is aligned to their intended purpose. This was a lesson we were able to share with other regions as they came on board.
- Data - the delay in getting access to the care plan data had implications around how the plans were rolled out. Now the data is readily available and provides us insights into how the plans are being used, enabling us to monitor the quality and consistency of plans being used across the regions.
- Behaviour change - changing health professional's way of working takes time e.g., having all health professionals in a care team contributing to one patient centred plan.

To read more about the Shared Care Plans and how they've made difference to our people, visit the Shared Care Planning webpage.