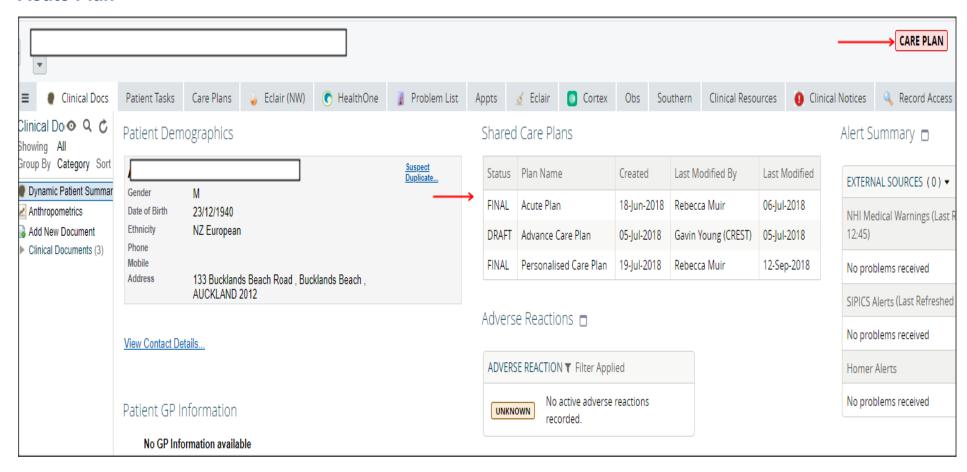
Shared Care Plans

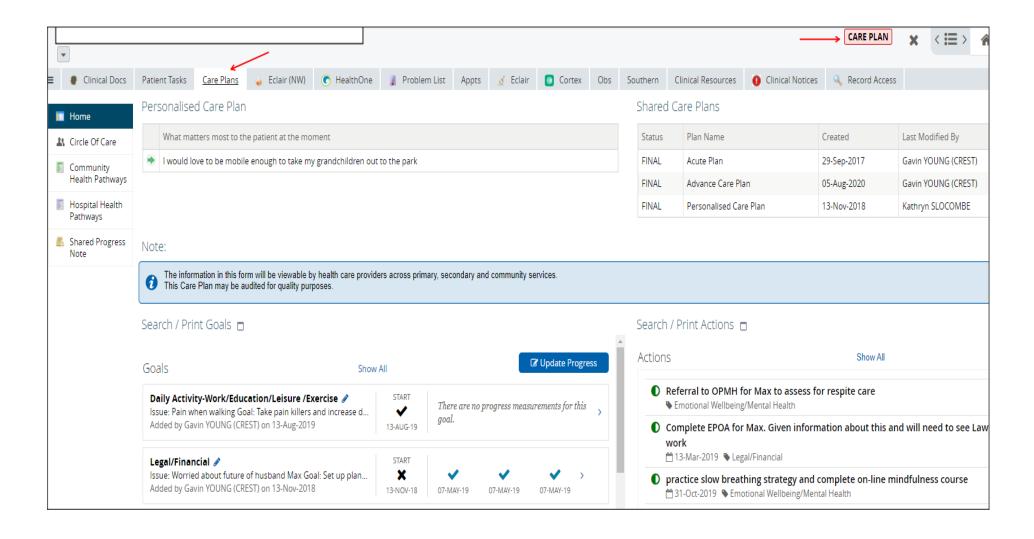
Where to find the plans

The plans sit within Health Connect South as below:

Acute Plan



Personalised Care Plan



How to get Started

Shared Care Planning - A guide to identification of vulnerable patients in general practice. For clinician use in the creation of the Acute Plan (AP) and the Personalised Care Plan (PCP)

Practice system/technology

- Query builds around specific condition/diagnosis. Pegasus -GP viewother practices - Dr Info
 - Conditions include COPD, other respiratory, CVD, diabetes, mental health, complex social issues, and age. Previous CarePlus high user card, palliative
- · Flu vac lists, COVID risk lists, frail elderly, and isolated lists
- Frequent attenders to the practice, criteria set by practice forexample: 6 visits in 6 months

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Provider referrals

- St John identify patients and phone or email the practice
- Māori health providers including Te <u>Puawaitanga</u> ki <u>Ōtautahi</u>
 Trustidentify patients and phone or email practice
- Community pharmacy referrals for patients on multiple medicinestherefore multi complex conditions
- Community providers e.g., CREST, district nursing
- · Mental Health NGO 's e.g., community support workers

CDHB Connections / Data Informed

- Lists of patients with Chronic Obstructive Pulmonary Disease
- Lists of patients at risk of inappropriate polypharmacy 10 or more medications matched to ED admissions
- Palliative leads make direct contact when a new patient is referred into their service
- ED daily presentations, summaries, and discharge reports

In practice identification by the Practice team

- Doctor identifies patients in consultation based on formedrelationship.
- Nurses identify patients via triage, working on the floor and in nurseclinic.
- · Spouse of partner with dementia or in care.
- Ethnicity
- Patients with cognitive or intellectual impairment or disability (e.g., hearing or speech) which impairs their ability to communicate effectively
- Patients that display difficult or challenging behaviour, have recurrent behaviour tending towards aggression
- · Patients who present with self-harm
- · Patients who present as drug seekers
- · Patients who present with recurrent falls
- Patients with rare conditions who need appropriate management in acrisis
- Patients requesting a plan as part of complaints resolution

Case Studies

Acute Plan

Sharon

Age: 28

Ethnicity: Māori

- Presents to acute services with severe abdominal pain 3-4 times a year
- She has severe endometriosis causing adhesions, infertility, recurrent small bowel obstruction
- She has a pain plan negotiated with pain clinic (copied in plan)

Plan could include:

- Please don't treat her as a drug seeker or talk much about pregnancy as both approaches will distress her
- Please manage pain as per attached pain plan and check for bowel obstruction

User and patient stories on the acute plan can be found here:

https://ccn.health.nz/Our-Work/Other-Alliance-Groups-Enablers/Shared-Care-Planning/ArticleID/5649 https://ccn.health.nz/Our-Work/Other-Alliance-Groups-Enablers/Shared-Care-Planning/ArticleID/5609 https://ccn.health.nz/Blog/ArticleID/1957

Personalised Care Plan

<u>Joan</u>

• Age: 77,

• Ethnicity: Pakeha

- You have completed an assessment on Joan aged 77
- She has diabetes and hasn't been coping at home with her husband.
- Carer stress, increase in diabetes symptoms
- Joan is well educated re what she needs to do to manage her diabetes but struggling with diabetes, lacks motivation.
- Sad about not being able to attend her granddaughter's wedding in 12 months due to being not well enough to fly
- Joan has been seen by Older Persons Health who can see and add to her PCP

Plan could include:

- What matters most to Joan "attending my granddaughters wedding in Australia"
- Goals: to lose 10 KG, identify relevant actions that will be required for her to achieve her goal.
- Document the goals and actions in the PCP, alongside this you can record the progress in the shared progress notes section.

Claiming for Plan

General practice can claim for preparation or full review of a shared care plan as follows:

Fee calculation:

Preparing or fully reviewing a plan usually takes around 10 to 30 minutes depending on complexity.

Claim process

Claim via Pegasus ePortal and include the following information in these fields:

- Other fee enter your fee
- · Other fee description
- Time taken to complete

More information about claiming can be found on health pathways

https://canterbury.communityhealthpathways.org/65695.htm

https://canterbury.communityhealthpathways.org/456252.htm

Need more information?

Community Health Pathways

Step by step guidance

Health Info

o Care Plan information for patients

Patient brochures are available electronically https://ccn.health.nz/Portals/18/DNNGalleryPro/uploads/2020/4/7/Sharedcareplans.pdf

Printed copies can be ordered from community and public health https://www.cph.co.nz/resources/shared-care-plans/

Canterbury Clinical Network Website

Additional resources available;

https://ccn.health.nz/Our-Work/Other-Alliance-Groups-Enablers/Shared-Care-Planning

https://ccn.health.nz/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core Download&EntryId=4719&language=en-GB&PortalId=18&TabId=2444

https://ccn.health.nz/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&Entryld=5396&language=en-GB&PortalId=18&TabId=2444

Contact the Shared Care Plan Team info@ccn.health.nz

Link to the Webinar Evaulation Form

https://forms.office.com/r/d2ZXTYunGs or Webinar: Shared Care Planning