COLLABORATIVE AOTEAROA

Care Planning in General Practice

GENERAL PRACTICE GUIDANCE DOCUMENT

About this resource:

This resource has been created to support general practices with care planning for priority patients. Care planning has been proven to support improved health outcomes and reduce general practice acute utilisation.

Contents

Acknowledgement

Collaborative Aotearoa extends their gratitude to the dedicated members whose commitment has significantly enriched an array of resources and would like to express appreciation to each member, Health Care Home Leads and Clinical Leads who has generously shared their time, expertise, and passion to create a comprehensive pool of resources, that empower and uplift our communities. In the development of this document the team gives credit to the following organisation:

- Tū Ora Compass Health Network
- Wellsouth Primary health network

Introduction

Providing proactive care to high-risk/high needs patients is crucial for improving health outcomes, reducing hospital admissions, and enhancing patient satisfaction. This comprehensive guide aims to equip general practices with strategies and tools to deliver proactive care effectively.

Shared Care Planning involves community, primary and hospital health care providers working together to proactively manage and plan care with patients who have complex health needs.

Shared care plans enable coordination and improved communication between health providers and up-to-date information sharing. The shared care plans in the South Island are accessed electronically, through HealthOne and Health Connect South - these are the digital health records health providers - and include Acute Care Plans and Personalised Care Plans, as well as the Advanced Care Plans.

Identifying High-Risk/High Needs Patients:

- Utilise population stratification tools to identify patients at high risk of adverse health outcomes.
- Consider factors such as chronic conditions, ethnicity, socio-economic status, mental health issues, and past healthcare utilisation patterns.
- Regularly review patient records and conduct assessments to update risk profiles.

Patients who would highly benefit from a Personalised Care Plan are:

- Patients who have moderate to high complexity health needs, including:
- Frailty
- 1 or more chronic conditions
- Complex social and medical needs
- Palliative care
- Long-term significant disability.

*acknowledgement to WellSouth PHO for their criteria for care planning eligibility.

Note: Check with your PHO re: funding and care planning eligibility criteria.

Establishing a Proactive Care Team:

- Form a multidisciplinary care team comprising general practitioners, nurses, allied health professionals, and social workers.
- There are large benefits in having a health coach lead care planning
- Assign roles and responsibilities within the team for care coordination, monitoring, and support.

Comprehensive Assessment and Care Planning:

- Conduct comprehensive health assessments to understand patients' medical, social, and psychological needs.
- Develop individualised care plans in collaboration with patients and their families, focusing on preventive measures, self-management strategies, and early intervention.

Examples of Care Planning Tools

- Indici PMS care planning tool

Shared Medical Appointments

A shared medical appointment, also known as a group medical appointment or shared appointment, is a healthcare model where multiple patients with similar medical conditions or health concerns participate in a group appointment facilitated by a healthcare provider, such as a physician, nurse practitioner, or specialist. Rather than traditional one-on-one consultations, shared medical appointments involve a group setting where patients have the opportunity to interact with both the provider and other participants.

Regular Monitoring and Follow-Up:

- Implement regular monitoring protocols to track patients' health indicators, medication adherence, and lifestyle modifications.
- Schedule follow-up appointments at appropriate intervals to review progress, adjust care plans, and address emerging issues promptly. By having pro-active planned appointments with the general practice care team the patient is less likely to attend ad hock.

HISO Standards

HISO is working with the Health Care Home Collaborative to develop and lead the adoption of common standards for interoperable shared care plans.

The requirements around interoperable shared care plans are to be able to:

- develop shared care plans collaboratively with the patient, including self-management and clinical management goals
- communicate shared care plans with other health providers and the patient
- copy shared care plans without loss of content between practices, whether using the same or different software.

This work will produce data standards, API standards and other standards for interoperability around shared care.

HISO 10074 Shared Care Plan Standard is in development and will define a minimum data set for communicating a goal-oriented shared care plan. Contact standards@health.govt.nz to see the latest draft.