National Health
Shared Care Plan
Programme
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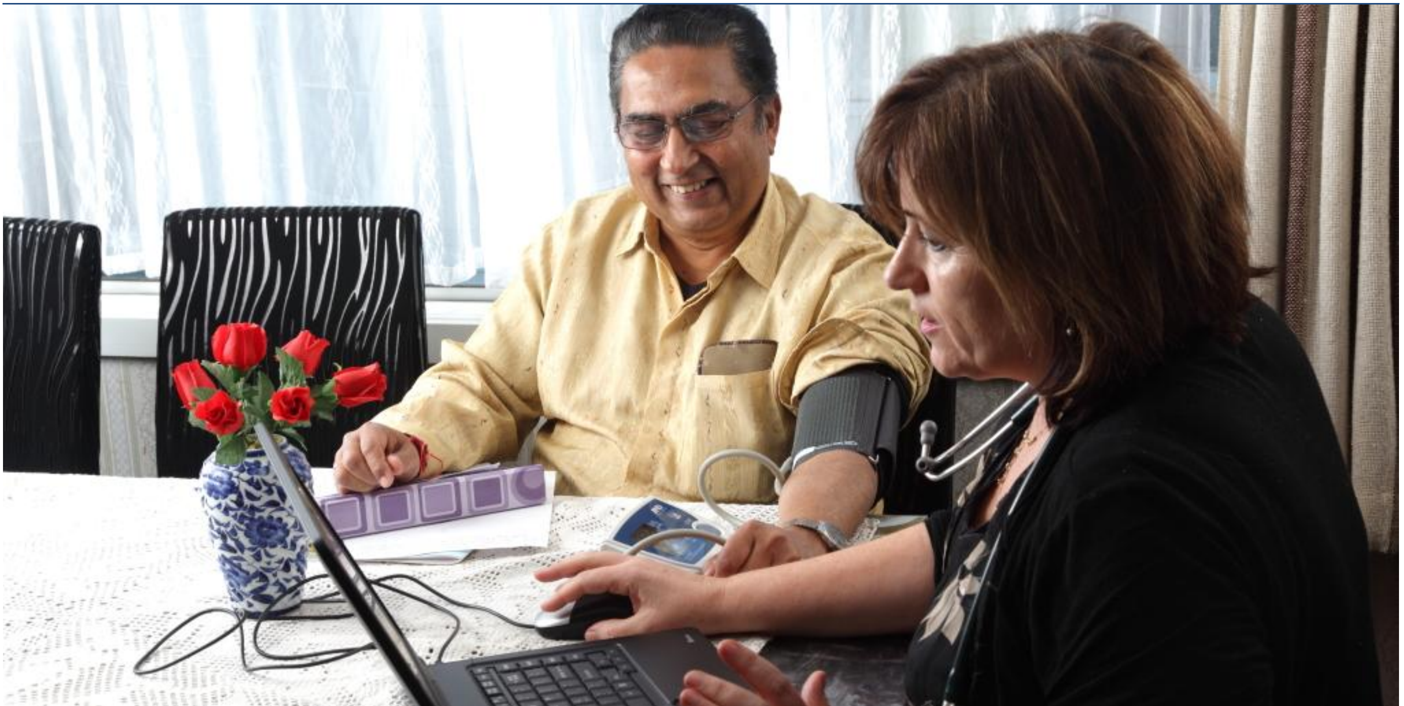
Shared Care pilot improves care management for patients with long-term health conditions



At a glance

- Three pilots are underway in the Auckland region to better manage the care of people with long-term conditions.
- Shared care is a person-centric approach, which involves all health professionals that have a role in the patient's care working to a common care plan and sharing information between them.
- Key benefits include increased patient involvement in managing their care, improved efficiency and better use of health resources, productivity and time savings, stronger patient relationships, improved safety, and better communication.

The need for change

In New Zealand people with long-term health conditions consume a major proportion of health care funds. Two-thirds of New Zealand adults are diagnosed with a long-term condition[1] and chronic conditions account for nearly 80 per cent of deaths[2]. The National Health IT Board recognises the need to manage the care of these people more effectively at home and in the community to minimise costly hospital visits. To do so, a select group of health professionals in the Auckland region are testing new approaches to shared care management for people with long-term conditions. Three pilots are underway across Auckland, Counties Manukau and Waitemata DBHs, as part of the National Shared Care Plan Pilot.

The objective of shared care planning is to improve the journey for people living with long-term conditions through patient participation, effective teamwork between the many services delivering their health care, and support for people to manage their conditions at home.

[1] Ministry of Health. 2008. *A Portrait of Health. Key Results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.

[2] National Health Committee. 2007. *Meeting the Needs of People with Chronic Conditions: Hāpai te Whānau mo Ake Ake Tonu.* Wellington: National Advisory Committee on Health and Disability.

The National Shared Care Pilot

The pilots initially involve eight GP practices in greater Auckland, several hospital speciality services including heart failure, gout and acute intervention respiratory services (AIRS), pharmacists and community care services. Auckland DHB is focusing on shared care plans for heart failure patients, Waitemata DHB is working with people with respiratory diagnoses who attend AIRS, and Counties Manukau DHB is creating shared care plans for patients with gout and metabolic syndrome. The shared care programme is underpinned by an electronic care plan and integrated patient management system developed by New Zealand health solutions company HSAGlobal.

The pilot is being managed by HealthAlliance and is jointly funded by the National Health IT Board and the three Auckland metropolitan DHB's.

Shared care in action

Mani Kant moved to New Zealand from Fiji in 1987 so his daughter could attend university. Now retired, he lives with his wife and his own 92-year-old mother, whom they care for in turn, in the Auckland suburb of Westmere.

Long standing and untreated hypertension has damaged Mani's heart and he suffers from heart failure.

His regular GP Dr Neil Hefford at the Grey Lynn Family Medical Centre has been using the Shared Care Programme since February 2011, and suggested to Mani that he join the ADHB-run heart failure pilot programme.

Dr Hefford uses HSAGlobal's CCMS software to enrol selected patients like Mani into the shared care system directly from his Practice Management System (PMS).

Dr Hefford and Mani work together to identify his main concerns and health problems and create a plan for managing these. The plan includes goals, actions and self-management activities that the patient and practice team will undertake to help manage his condition.

Professor Rob Doughty, a Cardiologist at the Auckland DHB Heart Failure service, Helen McGrinder, a Heart Failure Nurse Practitioner and his local community pharmacist are also part of Mani's care team, brought together by the shared care plan to help manage his care. Later, other health care professionals may be involved, such as a dietician.

Everyone involved in Mani's care can now access his record, view his 12 month care plan, request advice or services from other care team members, record notes, assessments and measurements and review and update his medications. Any changes or updates are shared with the whole care team. Members of the team can use the system to manage referrals, undertake virtual consultations, discuss Mani's care with each other or allocate tasks to other team members.

"Shared care is about putting the person at the centre of their care and involving them in creating an integrated plan for everyone who plays a part in managing their condition" - Dr Neil Hefford

"This is likely to include their GP, practice or community nurse, specialists, pharmacist and allied health professionals, but over time could also include social services, the person's extended family or a care co-ordinator who works as part of a local health network. With a shared care plan, none of these health professionals treat the patient in isolation and each has the full picture before making their assessment. The shared care pilots are the first step towards enabling people to have more input into decision making around their treatment and care and electronic access to their care plan."

Mani himself is central to the care plan. "I am now much more aware of my health and my programme," he says. "I pay more interest to it and follow the plan."

Mani's family can play a role in supporting him. While Mani does not use computers the goal is for patients and their families, such as Mani's daughter, to also access their shared care plans online.

"My wife keeps asking me questions about my plan and how I am doing. She says that it has got me on the right path!"

The GP as medical home

"Many patients view their general practice as their medical home," says Dr Hefford. "They have a trusted relationship with their doctor and want to visit the practice when they are unwell. A shared care plan means that the patient maintains that relationship with the doctor, but is able to benefit from the services of a wide range of other health professionals. We now all share access to the patient's details, and a common plan for managing their condition. The patient doesn't need to retell their story to each person that they see and the care team all communicate effectively in real-time, cutting out some of the common delays that are often caused by process."

"People often think of shared care as shared access to an electronic patient record, but it's so much more than that," says Dr Hefford.

The right care at the right time

For Helen McGrinder, Heart Failure Nurse Practitioner at the Auckland DHB, a shared care plan means that the person receives the right care at the right time in real-time.

"A shared care plan enables me to get involved early in the care of patients with long-term conditions through their GP, before they present acutely at the hospital," says Ms McGrinder. "I have the chance to get to know the person and to be fully involved in their care plan over time. It also means that these patients have access to specialist care earlier to help improve their quality of life, without going to hospital."

"My involvement in their care becomes proactive rather than reactive when they present in the emergency department." – Helen McGrinder

During one visit, Mani and Helen discussed sleeping and snoring issues. Helen was able to refer Mani to the Auckland DHB's Respiratory Service who arranged for Mani to stay overnight at the hospital for a sleep study, the results of which led to alterations in his care plan.

"Everyone knows what I have done and where I am at," says Mani. "My GP Dr Hefford sometimes says to me 'I have read your report from the hospital', so I know that everything is well coordinated."

Dr Doughty from the Auckland DHB Health Failure service says this proactive approach is key: "Shared care is about focusing on the health of the person over time, not just on the problem they have presented with today. It's about keeping people well and stable and preventing their condition from worsening to a point where they are admitted to hospital, by planning their care proactively. It's also about creating efficiencies in our health care system by sharing information between everyone involved, so the patient experiences continuity and a seamless process as they move between health care providers."

"This is not just about an IT system, it's about a fundamental change to the way that we work for the benefit of the patient and our health system."

– Dr Rob Doughty

If a patient that is part of the Shared Care Pilot ends up in hospital with an acute episode, hospital staff can access their care plan. This means that they can confidently treat the patient in the acute setting knowing their goals and care plan, baseline measurements, current medications and care team details. Information about the hospital visit is also shared automatically with the care team so that the care plan can be adapted if necessary.

"My experience is that when patients with a shared care plan do end up in hospital, it's often for a much shorter time as their condition is being better managed," says Ms McGrinder.

A person-centric approach

"Patients understand the concept of a shared care plan and appreciate discussing it with me and being a part of their own long-term care," says Ms McGrinder. "Often their biggest concern may be something like being able to play with their grandchildren, and I can ensure that the plan addresses their needs, which gets their buy in. By visiting them at home, I get a better picture of their individual situation and how it might impact on managing their condition.

"In the same visit, I can input information such as blood pressure, weight and heart rate directly into their record and make changes to their medication thereby improving their long-term outcomes. I no longer need to carry paper files or go back to the office and write up the day's reports. Any changes that I make while seeing the patient are shared with everyone in their care team, so that each health professional has a holistic view of that patient's overall care and the strategy for managing their condition over time."

Collaborative care

Janet Callender, a Practice Nurse at Grey Lynn Medical Centre, views this immediate sharing of information as vital in providing better care to her patients.

"With real-time two-way communication between primary and secondary care clinicians, I can see what Helen has done when she visits the patient at home," says Ms Callender.

"I don't spend my time with the patient trying to work out what has happened in the past and instead we can focus on what needs to happen in the future."

Patients also benefit from the information sharing between care providers. "My drug medication has changed a lot over the last few months," explains Mani. "But during Helen's visits I can get straight answers about why things have changed and what is to be done."

As well as the time savings that are made by not having to repeat patient information, redo tests or search for historical data, the shared care system improves productivity through electronic "service requests" between the various members of the care team. It also allows for virtual consults to take place with a wider care team.

"The patient can visit their GP, who records details and test results," says Dr Doughty. "As I am part of the care team, these are shared with me and I can conduct a virtual consult and come up with a treatment plan in conjunction with the GP. The patient doesn't need to wait for a referral to the hospital or be admitted to see me, and can continue to see their trusted GP."

Shared care in the future

The Shared Care Plan pilots will expand the use of shared care plans to more GP practices, a wider range of secondary services and up to 1,500 patients by December 2011. After this, an evaluation will take place to look at extending shared care to better manage the care of people with long-term conditions and minimise the cost of care to use our health system in the most efficient way.

To date Mani has not had an acute presentation at hospital, and the goal is for him to be able to continue living an active lifestyle, enjoying time with his grandchildren and in his garden.