Planned Proactive Care: *Care Closer to Home*

PROGRAMME IN CONJUNCTION WITH COUNTIES MANUKAU HEALTH

* As at 30 June 2017

29,213* TOTAL PATIENTS

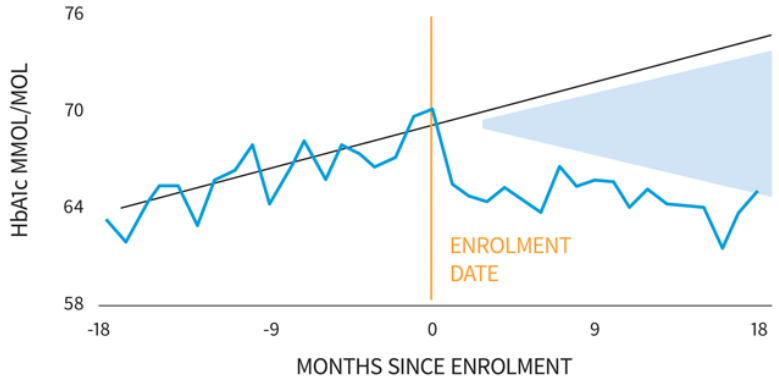
12,487* PROCARE PATIENTS

A primary-care-led initiative designed to better support people with long-term conditions. Other risk factors, such as inadequate housing or low health literacy, may be compounding conditions such as **diabetes or heart disease.**

BENEFITS

- Patient-centred care planning
- Care coordinator assigned to each patient
- Flexible funding to allow individualised packages of care
- Multi-disciplinary teams
- Shared technology system
- Change management
- Business modelling
- Improved access to specialist care

IMPROVED DIABETES MANAGEMENT (EARLY OUTCOMES – HbA1c)



HOW IT WORKS

1. **Risk stratification** and clinical judgement to identify individuals.

2. Special consultation to create **patient centred care plan.** Plan holds identified goals and time milestones.

3. Shared plan activates **coordinated suite of clinical and social support.**

4. **MDT case conferences** held if needed. Plan is reviewed, updated and altered. ▶ **Coordination Team** ▶ Care coordinated to achieve documented goals.

5. **Review** after one year and patient graduated from programme or re-enrolled. Early exit if mutual decision not to continue.

ProCARE