

Planned Proactive Care: *Care Closer to Home*

PROGRAMME IN CONJUNCTION WITH COUNTIES MANUKAU HEALTH

* As at 30 June 2017

29,213* **12,487***
TOTAL PATIENTS PROCARE PATIENTS

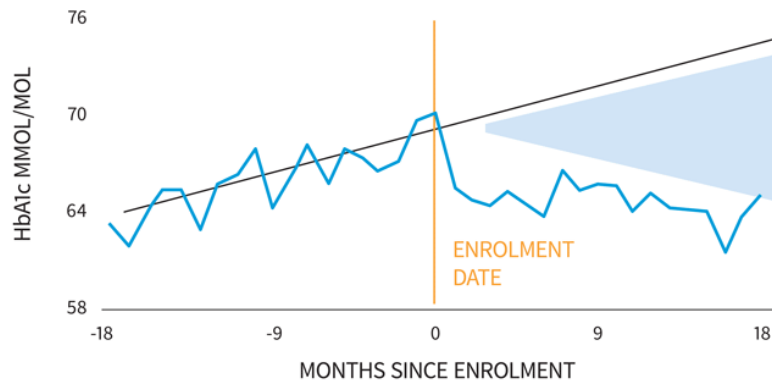
A primary-care-led initiative designed to better support people with long-term conditions. Other risk factors, such as inadequate housing or low health literacy, may be compounding conditions such as **diabetes or heart disease**.

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.**

GP, PRACTICE NURSE, PHARMACIST, SOCIAL WORKER, SMO, PSYCHOLOGIST, DISTRICT NURSE, OTHER A/H
- 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.**