Long Term Conditions Management Programme and Health of the Older Person Project

WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Why the new approach?

Objectives

- General practice-led management of long-term conditions, the frail elderly, and those at high risk of re-admission.
- Utilising Risk Prediction Tool to identify patients
- Building patient self-management and health literacy in all interactions.
- Supported by a long-term conditions team in the community, by secondary care, by self-management, and by health promotion.

CLIC process overview

1. Practices assess patients, assisted by a comprehensive health assessment on WellSouth portal
2. Patients are stratified into 1 of 3 levels
3. Funding is linked to the level
4. A package of care standardised for each level is delivered

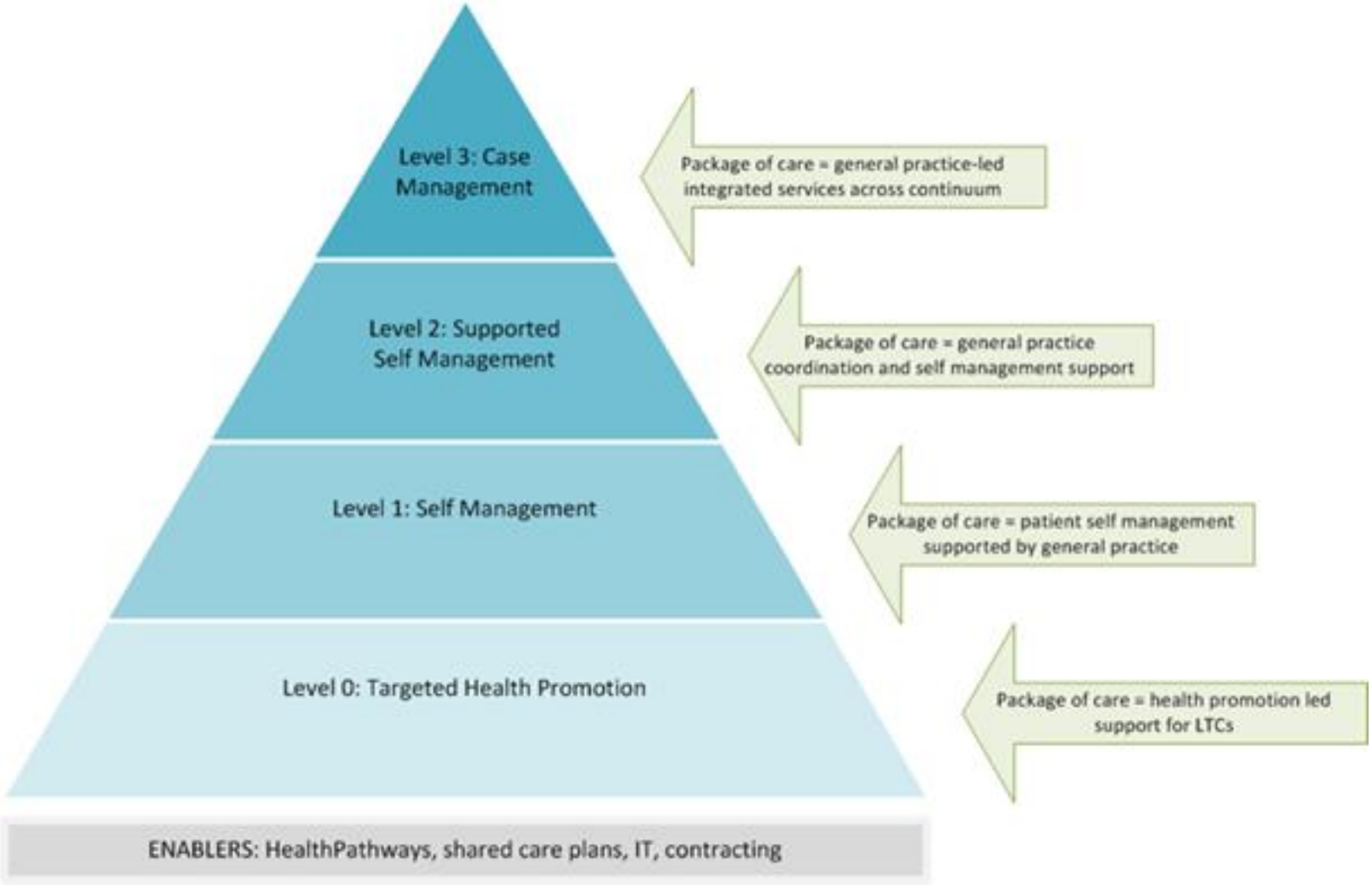
CLIC Packages of Care

Level 1 – CHA and usual General Practice

Level 2 – CHA, personalised care plan, acute care plan and advance care plan

Level 3 – CHA, personalised care plan, acute care plan, advanced care plan and MDT meeting

Stratification Levels



Risk Prediction Population Overview

	Very High	High	Low	Unknown
Practice Patient Count:	14	36	936	0
Practice Population %:	1.4 %	3.7 %	94.9 %	0.0 %
WellSouth Population %:	2.0 %	5.0 %	93.0 %	0.0 %
Practice Avg Age:	75	75		
WellSouth Avg Age:	79	78		
CarePlus Registered:	7	5	30	0

Patient List

CarePlus Registration Criteria

Criteria 1: *Expected to need "intensive clinical management" over the next 6 months* ***Criteria 2:*** *Has had six First Level Service primary care visits in the past six months*
Criteria 3: *Has had two acute non-surgical admissions in the past twelve months* ***Criteria 4:*** *Has a terminal illness* ***Criteria 5:*** *Has had two or more chronic conditions* ***Criteria 6:*** *Is on active review for elective services*

NHI	Risk Score	Risk Level	Age At Census	Ethnicity	CSC	Palliative Care	Total Care Plus Registrations	Current Care Plus	Registration Date	Criteria 1	Criteria 2	Criteria 3	Criteria 4	Criteria 5	Criteria 6	Care Plus Registered Conditions	Post Census Hosp Adm	Post Census EDAttend
	97.96	Very High	66	NZ European/Pakeha			2	Yes	02/02/2017	1				1		Non - Hodgkin's lymphoma, Haemochromatosis, Second.dilated cardiomyopathy, Atrial fibrillation, Chronic renal failure, [D]Prediabetes		
	94.99	Very High	82	NZ European/Pakeha	Yes		4	Yes	10/05/2017	1				1		Total colectomy+ ileostomy NEC, Hypothyroidism, Hyperlipidaemia NOS, Gout, Anxiety with depression, Essential hypertension		
	92.88	Very High	52	NZ European/Pakeha	Yes		3											
	92.84	Very High	96	NZ European/Pakeha			1	Yes	06/08/2016	1		1		1		Iron deficiency anaemias, Essential hypertension, Aortic aneurysm		
	92.57	Very High	94	NZ European/Pakeha	Yes		3	Yes	19/04/2017	1	1			1		Non-ins-dep diabetes mellitus, Senile/presenile dementia, Diverticulitis, Osteoarthritis		
	92.36	Very High	76	NZ European/Pakeha	Yes													

Comprehensive Health Assessment

Patient | Provider | General | Conditions | Functional Health | Mental Health | Biometrics

Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday actvities such as eating, getting dressed, grooming, bathing, walking or using the toilet?

Please Specify

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

Please Specify

Action:

Please specify

Medications

How often do you have trouble taking medicines the way you have been told to take them

Please specify

Sleep

Each night, how many hours of sleep do you usually get?

0 hrs

Do you snore, or has anyone told you that you snore?

Please Specify

In the past 7 days, how often have you felt sleepy during the daytime?

Please specify

Comprehensive Health Assessment Summary for MINNIE MOUSE (GXX3030)

Stratification Level	Flinders Scale
Level Three	**High Self-Management Capacity (70)**

Package of Care Requirements

Personalised care plan (patient's goals) and 1-3 monthly review of it.
Acute care plan: Clinical management plan to manage exacerbation, including action plan for patient.
Multi-disciplinary team meeting, as required (including with social agencies).
Advance care plan.

Actions

Physical Activity: **Referral to Green Prescription**
Diet and Nutrition: **No Further Action/Under Review**
Alcohol Use: **Referral to Specialist Service**
Tobacco Use:
Pain: **Referral to GP**
Oral Health: **Oral Health Advice**
Activities of Daily Living: **Advice re: Community Service**
Mental Health: **Brief Intervention Referral**

Assessment Details

General Health

Assessment Date	**18 Sep 2017**	In general, would you say your health is?	**Good**

Physical Activity

How many days have you exercised in the past 7 days?	**2**	On days when you exercised, for how long did you exercise?	**10**

Health of the Older Person Project

CLIC
Client-led Integrated Care

WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Where has this occurred?

What has occurred?

- 50 patients over 75 years were identified via a risk prediction tool as being very high risk of hospital admission
- Each patient underwent a Comprehensive Health Assessment via WellSouth Portal
- 19 patients were identified at Level 3 (complex)

Issues identified for patients

- Increased falls risk
- Polypharmacy
- Social Isolation
- Equipment required

Clinical Pharmacist Intervention

- 18 patient's medication reviewed during a single home visit with WellSouth Clinical Pharmacist
- 10 medicines recommended to be reduced/stopped.
- 8 medicines recommended to be started/increased. (mostly Vit D) 5 switches of medicines (one to another) recommended and 3 medicine cards written
- 14 patients educated about their medicines/medical conditions
- High PIH score (over 70), more likely to have good routine for taking medicines

B-Well Falls Programme Intervention

19 patients all assessed by falls team

12 commenced on In Home Exercise Programme

1 continuing on community based programme

1 declined

5 did not meet service criteria

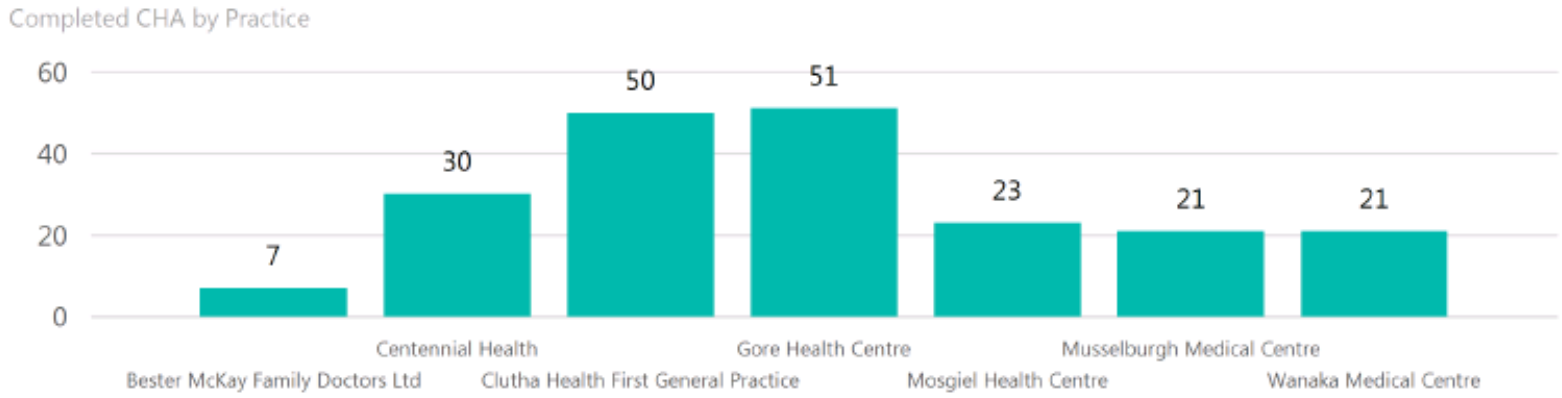
Where to from here?

- Continue to monitor the 19 identified patients
- Further roll out of CLIC programme across the 84 General Practices in the Southern District
- 4 hour education sessions being delivered

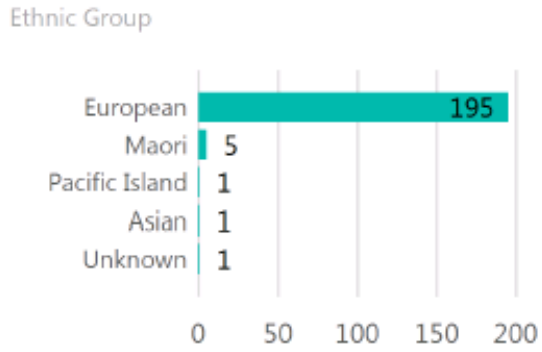
Completed Comprehensive Health Assessments

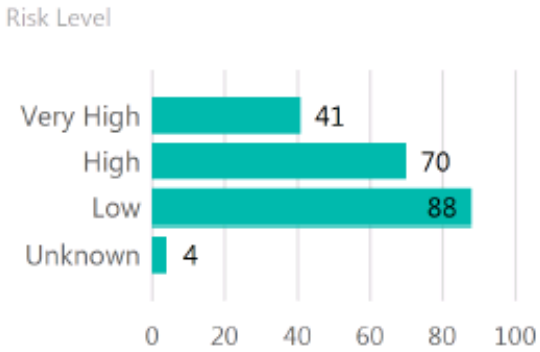
Quarterly Report: Q2 2018

Total Completed Comprehensive Health Assessments: 203

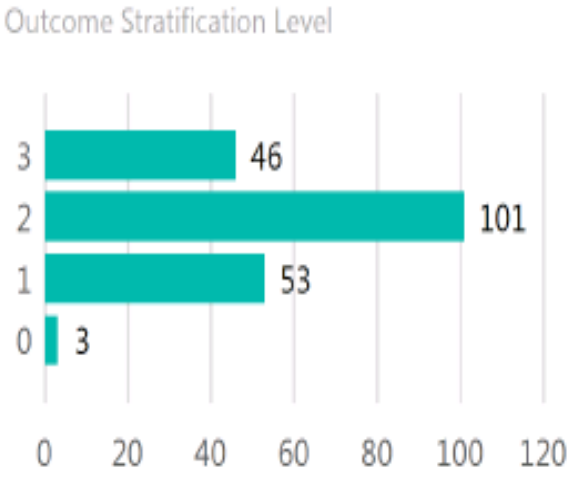


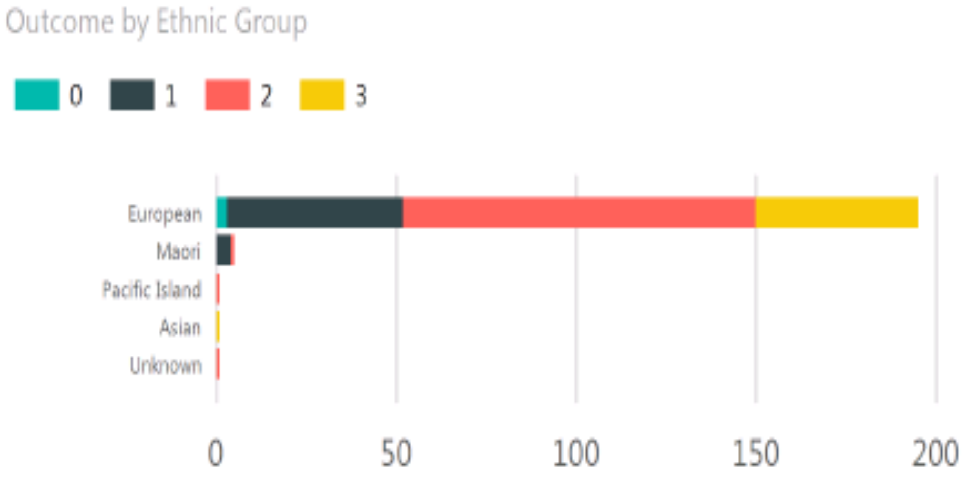
Patient Profile

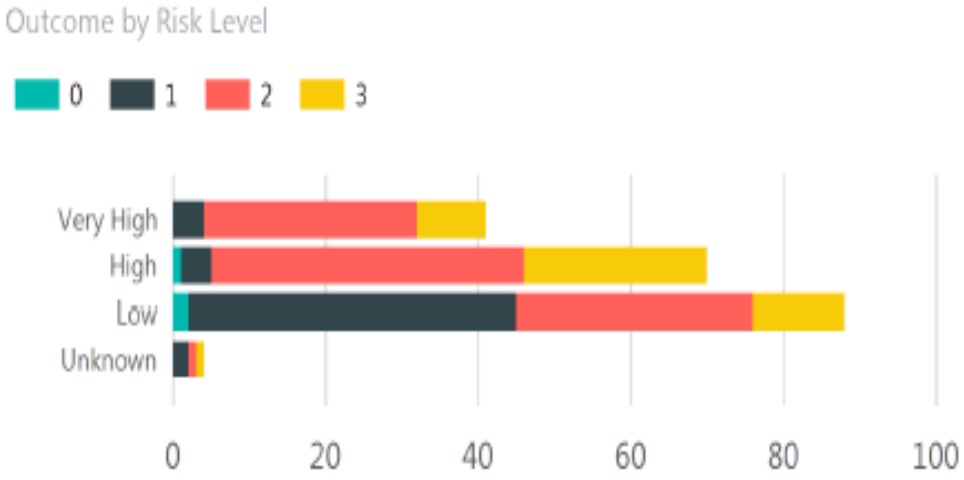




Assessment Outcomes







Questions

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