Client-centric service co-ordination in a "joined up" health system

NASCA Forum

3 September 2015



Agenda

- Connected Care
- CCMS
- Patient scenario "connected care"
- Service co-ordination features within the scenario
- Questions and discussion



About us

CCMS helps health and social care leaders deliver new models of connected care to high needs populations

- With our Shared Care Planning and Management software
- Our integration capability
- Our implementation experience

"putting individuals and families at the centre of everything we do"



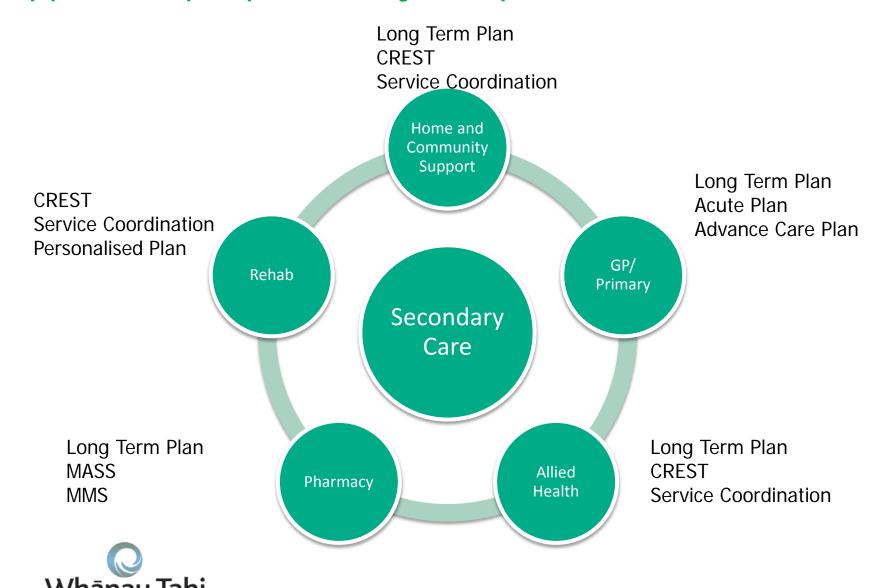
Supporting people wherever they are

Secondary Care





Support for people to stay independent closer to home



NAVIGATING WAYS TO ASPIRATIONAL OUTCOMES

Real benefits realised ...

Better patient experience:

- 84% of clients set their own goals and said programme enabled them to regain their independence.
- 77% of clients believe programme's support stopped family members feeling over-burdened.

Improved health outcomes:

- Improved clinical outcomes (standard assessment tools) and reduced the Average Length of Stay per patient without increase in readmission rates for supported early discharge programme
- Improved quality of life reported by participants

Less waste:

- 34% reduction in bed days used by enrolled patients
- 36% reduction in ED presentations from enrolled patients
- 13% reduction in Residential Aged Care bed utilisation



Our CCMS Product

A powerful platform for improving patient outcomes

We have built a complete connected care platform which enables a network of carers to proactively manage care



Personalise

Move away from uncoordinated, conditionspecific responses by putting the person at the centre of care and recording their goals.



Connect

Provide a central platform that enables everyone involved in a person's care network to identify each other and understand their role in supporting patient goals.



Communicate

Ensure everyone in the care team, including the patient, can easily communicate with each other when they need to.



Plan

Keep everyone on the same page by enabling the co-creation of a centralised person-centred care plan.



Manage

Enable the care plan to be actively managed through workflow management, task allocation, task monitoring and ongoing reassessment.



Measure

Measure the effectiveness of the plan and its progression toward patient goals while gaining greater visibility of resource coordination and service delivery.

Core Modules

- •Identification & Enrolment •Care planning Team Assessment Progress Notes •Plan Development Action lists •Plan Implementation Communication •Plan Tracking/Follow up Smart Prompts Service Management •Person – Self Care (Portal) Reporting Care Planning & **Collaboration &** Communication Management Demographics Person Index Consents Provider Index
 - Conditions, MedicationsAllergies, Immunisations

•Scheduled/Unscheduled

•Measurements, Results

Whānau Tahi

Events

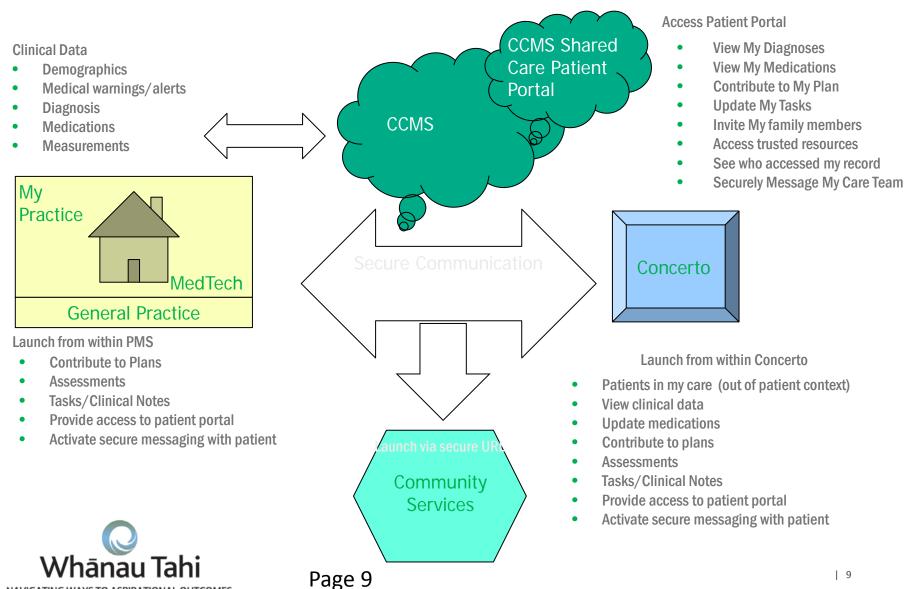
•Document Repositories

Pathways

Provider Systems

Decision Support/Clinical

How does it fit?



NAVIGATING WAYS TO ASPIRATIONAL OUTCOMES

Some recent news

- Hawke's Bay DHB implemented CCMS successfully in July to use for NASC Service Coordination (Options Hawke's Bay)
- Integration with MedTech, MyPractice, Concerto, LOTS, Toniq, InterRAI, Éclair, e-Sam and more to come
- Canterbury, Northern Region and Hawke's Bay DHB's signing 3 year contracts (approx. 40k patients and growing >1.5k per mth)
- Meds Adherence Support Service rolling out in Auckland and MMS in Canterbury
- Revised licensing model with low start up costs and price based on value
- Northern and Canterbury user groups established driving changes to Care Plan and Task/ Messaging
- Acquisition of CCMS by Whanau Tahi Ltd enables us to close the loop on connected health and social care and family-directed care – very exciting!!!



Sally Snow

Profile:

Age 83

Social Situation:

- Currently living alone at home; Independent in her activities of daily living
- Finding it increasingly difficult to make meals and do household chores
- Has family support
- Not getting a lot of exercise

Physical Challenges:

- Non-insulin-dependent diabetes mellitus (Type 2) requiring insulin
- Hypertension
- Obesity, and
- Gastroesophageal reflux disorder

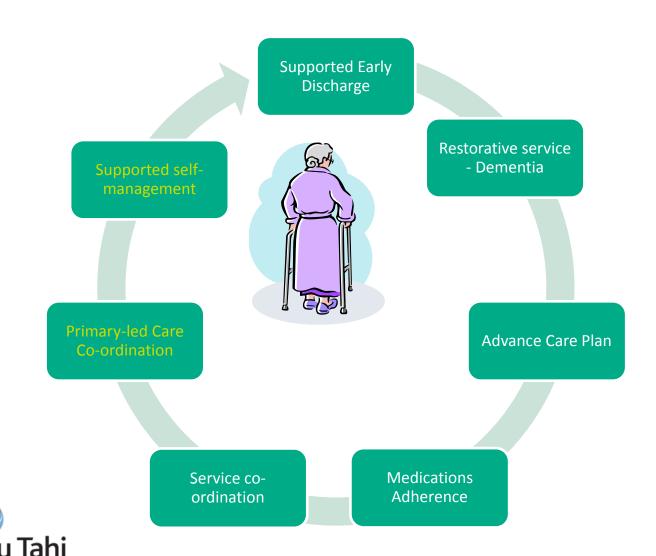


Sally Snow - Risk Profile

- Progression of Diabetes due to poor weight control
 - Requires insulin support
 - Eye Sight issues
 - Renal issues
 - Progression of her Heart Failure
- Poor blood pressure controls worsened by Obesity; contributing to heart disease - CVD
- Falls Risk with potential fracture due to developing Osteoporosis
- Confusion (memory problems) forgetting her Meds

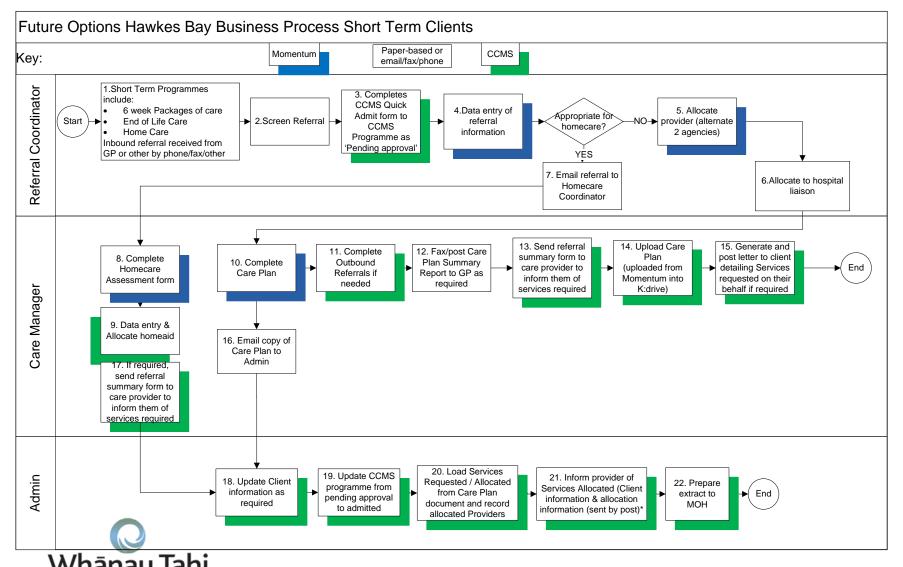


Sally needs a "connected" health system

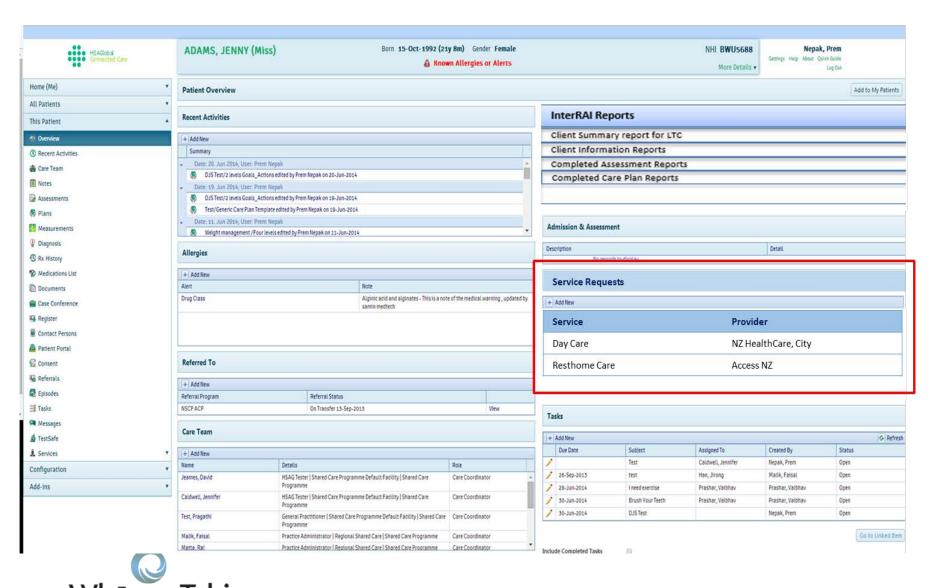


NAVIGATING WAYS TO ASPIRATIONAL OUTCOMES

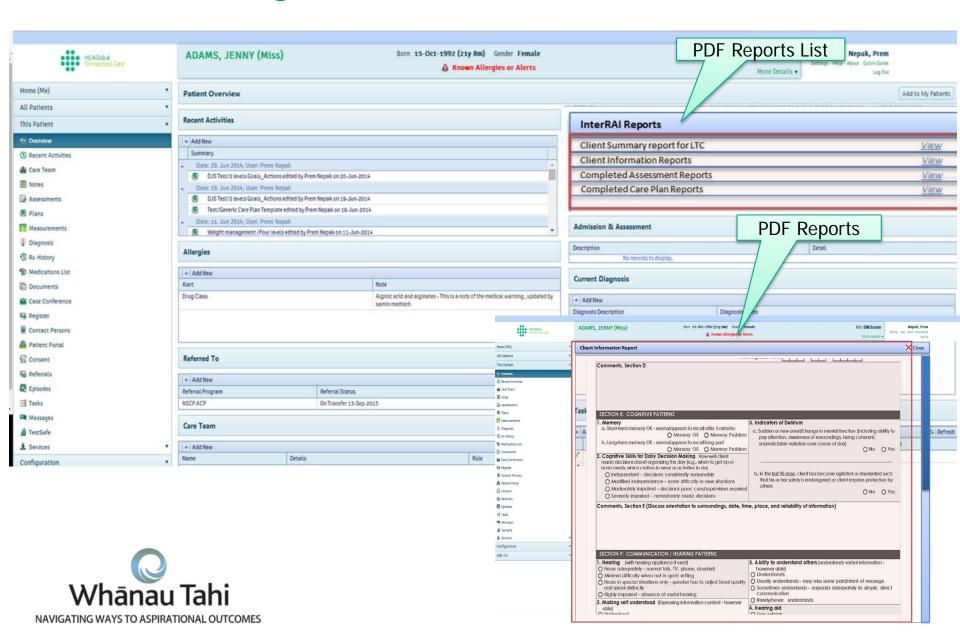
Service co-ordination workflow in CCMS (HBDHB)



NASC can "see" Sally holistically



Including her InterRAI assessments

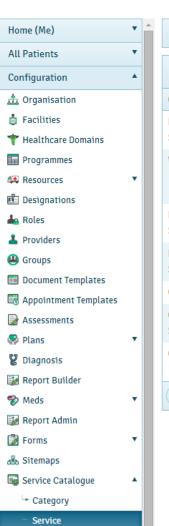


Select from available services for Sally



Nepak, Prem

Settings Help About Quick Guide Log Out

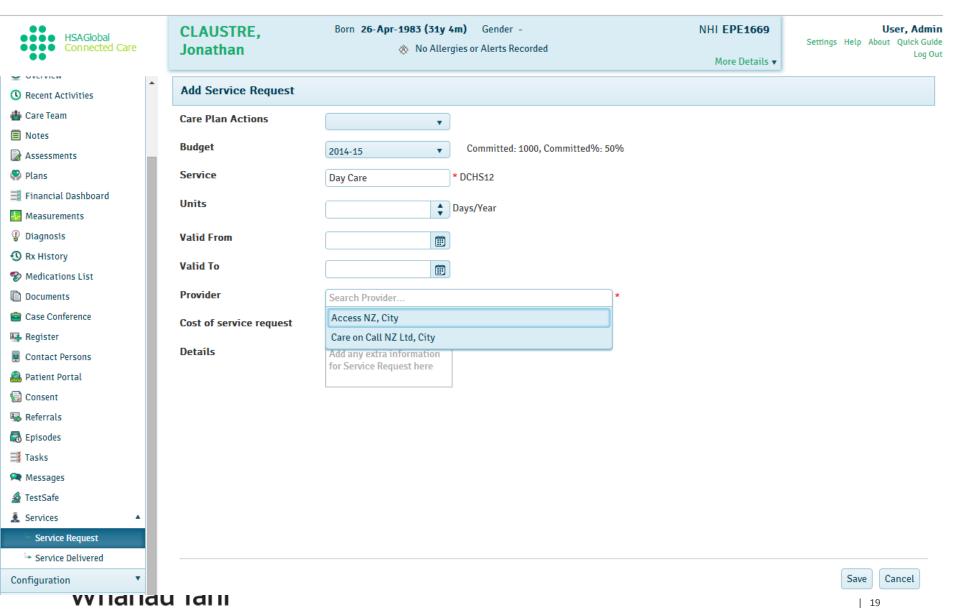


Motifications

Service								
+ Add New								
Category 🔻	Service 🔻	Code 🔻	Unit of Measurement	Type 🔻	Valid From	Valid To 🔻	Status 🔻	Description T
Home Based Services	Ali's Home Help	159	Units/Day	Quantity Based			Active	
Wound Care	bandaging	546546	Visits	Time Based	04-Jun-2014	04-Jul-2014	Active	Wound care - bandaging for hurt folks
Home Based Services	home care	12345	Hours/Week	Time Based			Active	test
Home Based Services	Home Help	нн	Hours/Day	Quantity Based			Active	asdfg
Cleaning	Jens Cleaning	Cl1	Hours/Week	Time Based	21-May-2014	28-Jun-2014	Active	
Community Services	Personnal Care	xxxxx	Hours/Week	Time Based			Active	
Cleaning	Spectacles	Clean1	Visits	Quantity Based			Active	visits
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View Details

Understanding Sally's needs better helps service selection

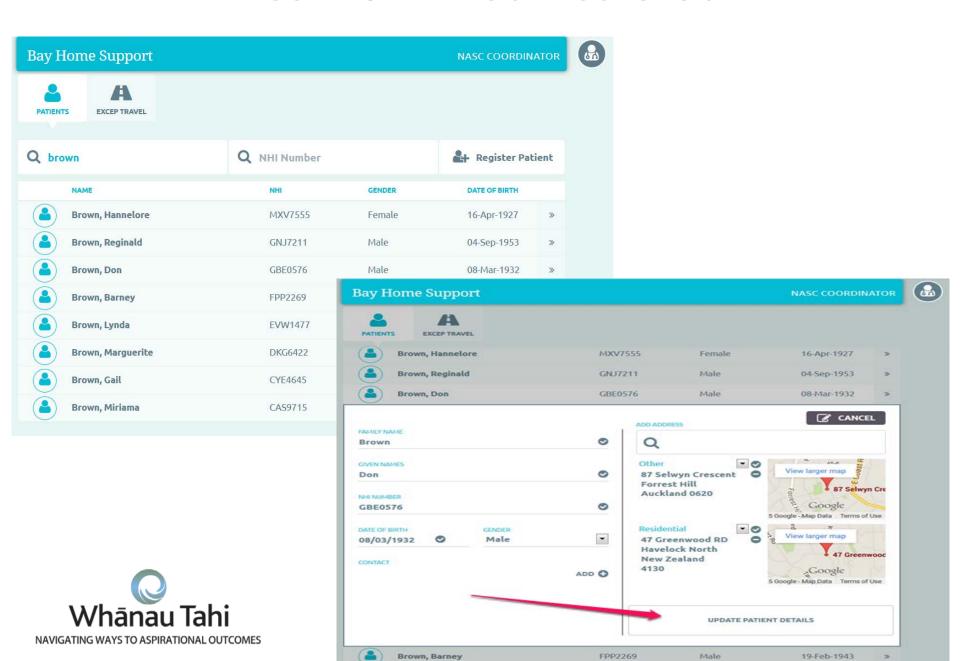


And service visibility for all

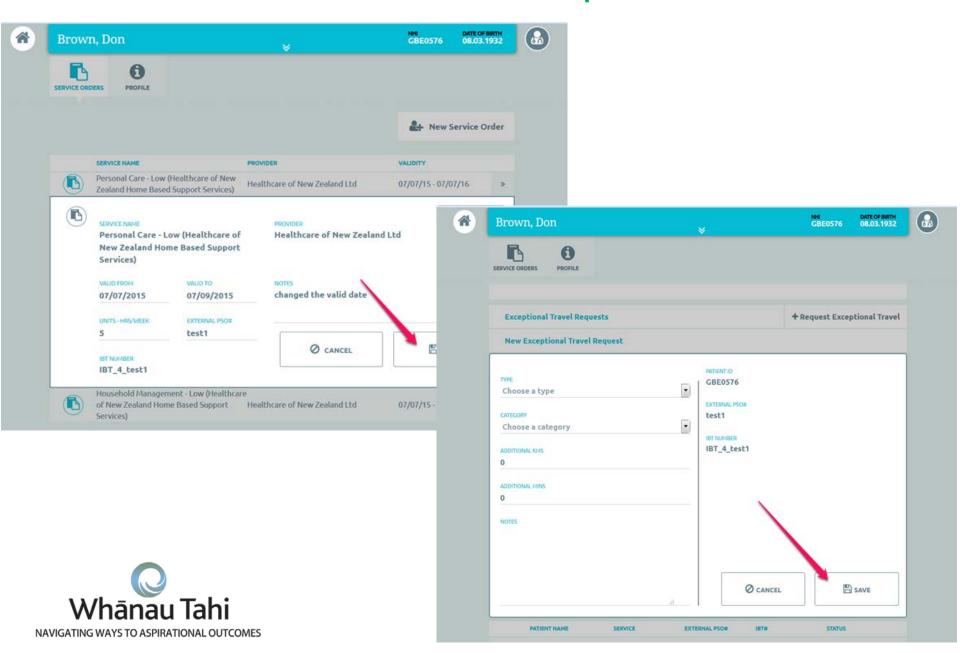
Created Date	From		То				Filt
+ Add New							
	Service 🔻	Units UoM	Valid From	Valid To	Provider T	Status	Ţ
	Young Persons Disabled	1 Days/Year	01-May-2015	02-May-2015	Cairnfield House - LTS	CANCELLED	
+	Home Support	1 Hours/Day	05-May-2015	31-May-2015	Access Homehealth - LTS	ACTIVE	
•	Home Support	2 Hours/Day	08-May-2015	31-Jul-2015	Access Homehealth - LTS	ACTIVE	
	Home Support Household Management				Hutt Valley NASC	ACTIVE	
	Home Support Household Management	0 Days/Year			Access Homehealth - LTS	CANCELLED	
	Home Support Household Management	3 Days/Year	15-May-2015	23-May-2015	Kerikeri Rest Home	CANCELLED	
1	(H)		ı			1 - 6 of	f 6 item

+ Add	New						
	Budget T	Amount y	Committed T	Spent T	Committed %	Spent % ▼	Status
1	care centre	5,000.00	27.00	25.00	1%	1%	Active

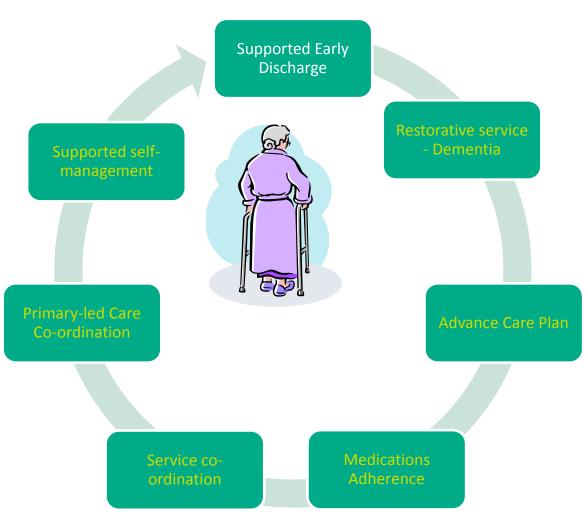
E-Sam & IBT Service Order



Service orders and exceptional travel



Connecting care



Key points

- Sector-level view
 - Client-centric connected care is happening
 - There are benefits for patients, families and providers across the continuum
 - Service co-ordination is a key element of connected care
- NASC level view
 - Specialist functionality available to meet department needs
 - "Connected Care" not a pre-requisite to improving the way we manage patients
 - NASC's are key players in improving patient outcomes



Thank you

Questions

- For more information:
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