WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Long Term Conditions

SHARED CARE PLANS – Presented by Viv Williams

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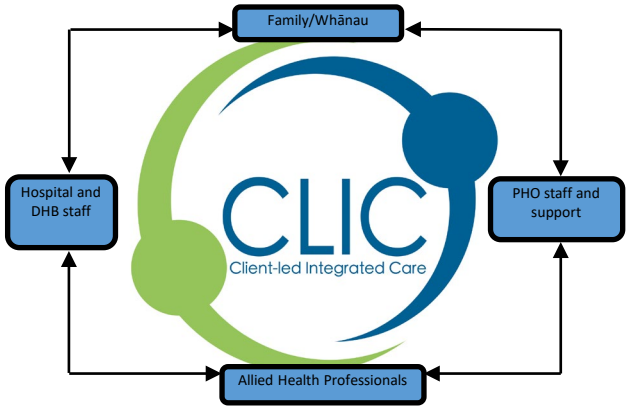
LETS CLIC TOGETHER: A FUNDAMENTAL CHANGE

The overarching goal of the CLIC programme is supporting the client who has a long term condition to self manage their condition in partnership with their primary health care providers.

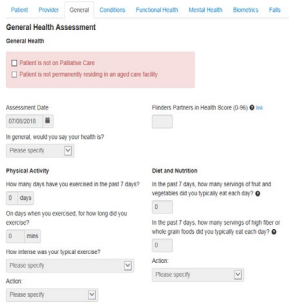


What is the Client Led Integrated Care (CLIC) programme?

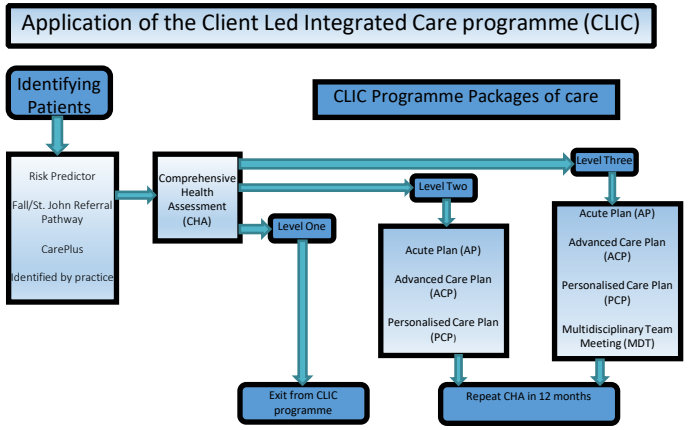
- Replaces CarePlus
- Grounded in building self-management capabilities
- Enhances health literacy of people with long term conditions
- Improves communication across the system to improve planned and acute care
- Offers funding packages most appropriate to clients level of need
- Begins with a Comprehensive Health Assessment (CHA)

Key Milestones/Achievements:

- Commitment to the success of the roll out from Day 1
- User testing and redevelopment on the fly
- Growing the process from the ground up
- Shifted funding to people that need it the most
- Opportunity to deliver care in an innovative way back to the practice



First tab of Comprehensive Health Assessment Tool



How has CLIC been instituted into Practice?

- User testing sites commenced September 2017
- Full rollout commenced early 2018
- Commencement of CLIC only begun with agreement of timing with each practices
- A four hour education session offered to clinicians within practices
- A Long Term Conditions nurse supported the practice on site on the day they changed from CarePlus to CLIC

What next after CLIC introduced?

- Ongoing support for practice nurses with Long Term Conditions nurse
- Education for clinicians around care planning with their clients
- Utilizing multi-disciplinary team for level 3 clients

Some Learning and Challenges for Practices

- Time challenge with one hour being allocated to CHA
- Upskilling required around care planning
- Practices need follow up and support with such a big change
- Beginning the conversation about Advanced Care Planning
- Being unable to access Health One in the initial stages of rollout
- Explaining the changes to clients, especially if they are level 1

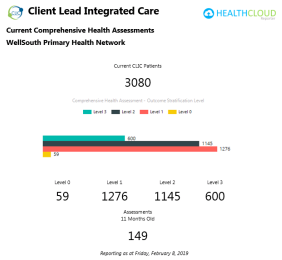
Feedback from practices using the CLIC programme

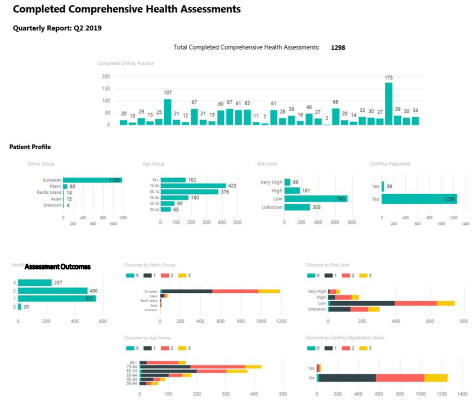
- *"We've found the CLIC [programme] to be a helpful tool, especially for the high needs patients we care for"*
- *"Our nurses are saying that the CLIC programme identifies medical conditions that haven't been recognised in the past and that CLIC is very thorough."*
- *"Some of patients have requested CLIC after hearing good things from other patients"*
- *"We are looking forward to seeing how CLIC impacts the overall health of our patient population"*
- *"Our patients have really appreciated having their healthcare team set aside time to truly listen to the things that are important to them.*
- *Our therapeutic relationships with our patients have become deeper as we learn more about them.*
- *We have learnt things about our patients that wouldn't have otherwise come up in a standard consult, and because of this we are able to work on a more personalised care plan that is actually relevant and beneficial to our patients."*

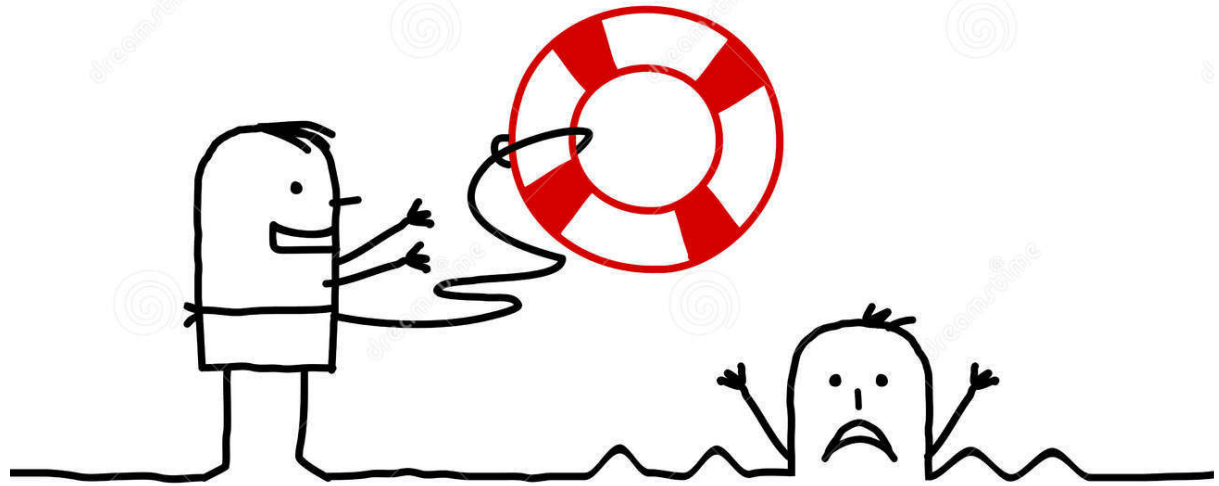
RN Nicola Stout discusses with her patient what the Comprehensive Health Assessment means

The Numbers So Far

Currently CLIC has been rolled out to a total of 43 General Practices across the WellSouth PHO.







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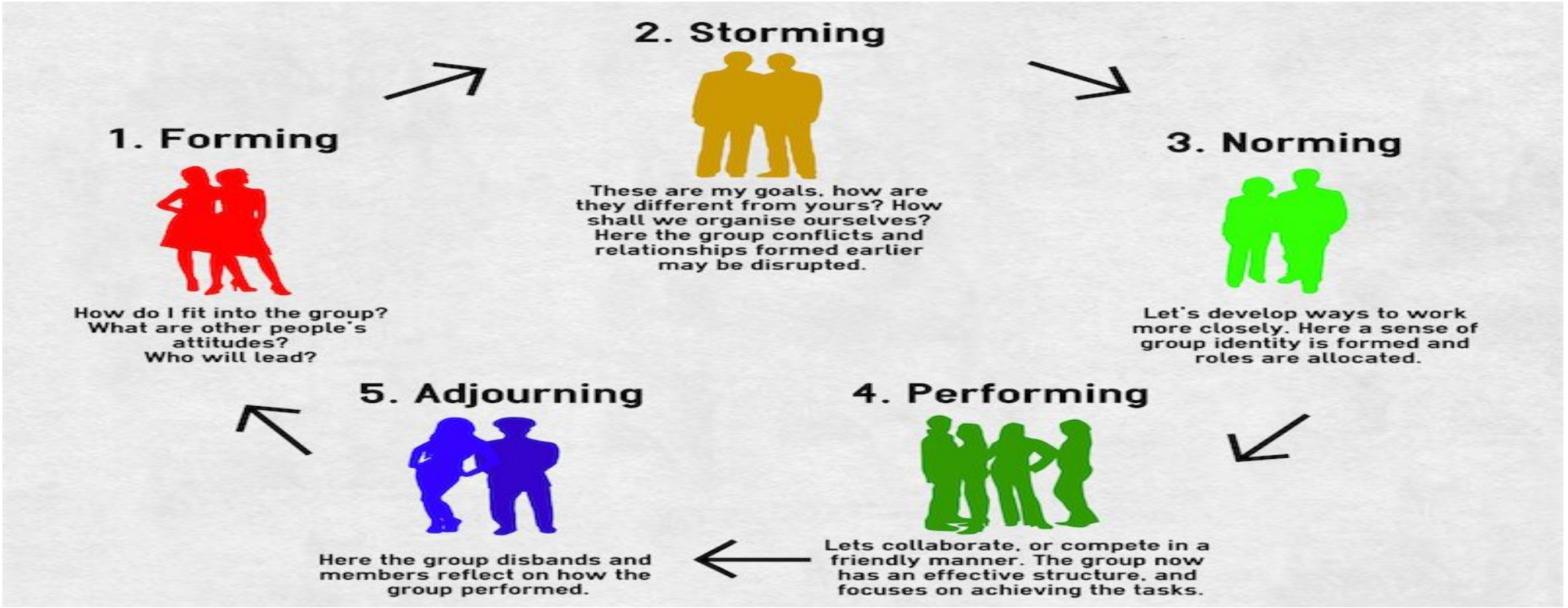
Tuckman's Change Model



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STORMING

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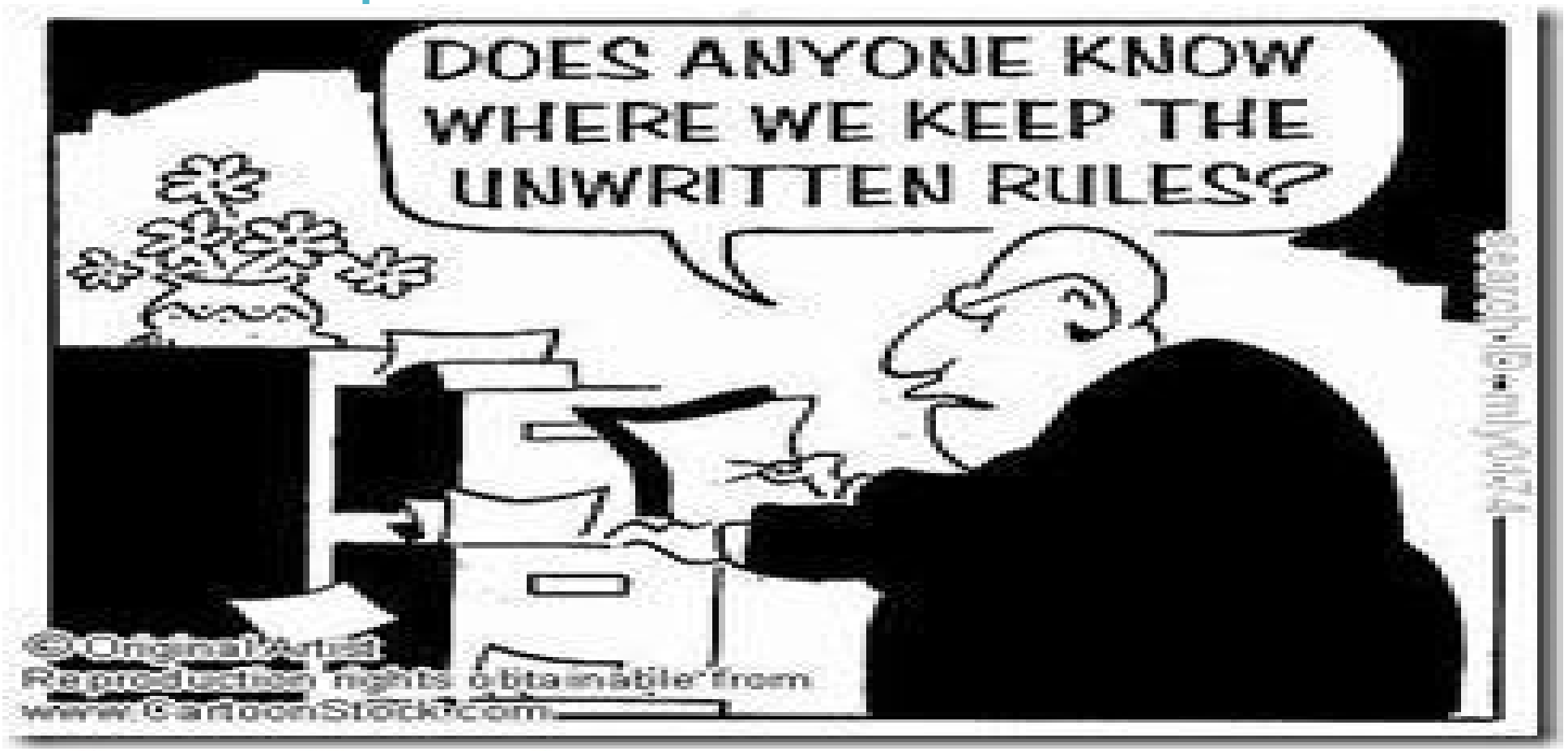
Assumptions



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Remaining Calm

Norming Stage

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Performing Stage

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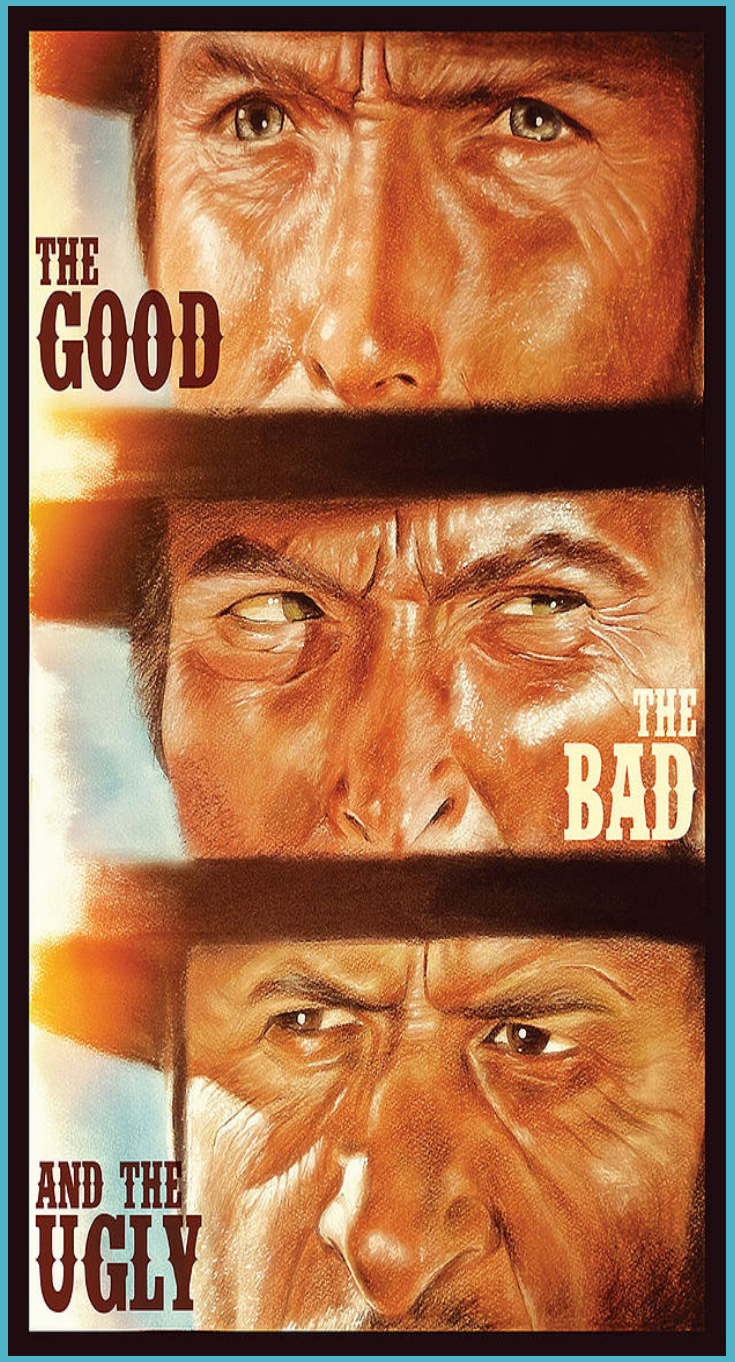
What worked well:

- Relationships which were developed
- Being the key contact person for Care Plans

What did not work so well:

- Resources on Health Navigator were not clear
- Too many changes introduced at once



Conclusions

- Video
- Laminated steps for each care plan
- Teach one care plan at a time
- Have more, more timely collegial support in the different geographical areas