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Conference Abstract

Coordinating Care around complex patients- an innovative approach

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Abstract

Collaborative Care uses the Connected Care Management Solution software to bridge the gap between health care providers and support new ways of working with patients who have complex health needs. Safe sharing of patient centred care plans provides a platform for more effective communication, forward planning and collaboration across care teams. Historically, care has been provided across disparate health services unable to view or contribute to the work of other health professionals working with the patient. The programme aims to connect health professionals to provide optimum appropriate and timely care and support the patient to manage their own health needs and goals.

This programe supports the Canterbury District Health Board vision of delivering the right care in the right place at the right time.

Key innovations include:

Updatable care plans which can be viewed, added to and edited across secondary, primary and community services .

Close collaboration with allied health and emergency response providers

Acute plans viewable and editable by clinicans right across health system

Advanced care plans

Development of a care coordination function in primary care

Patient centred planning wrapping services around patients own needs and goals

Working closely with software provider to support clinical work and patient needs

Keywords

Integrated care for patients with complex needs