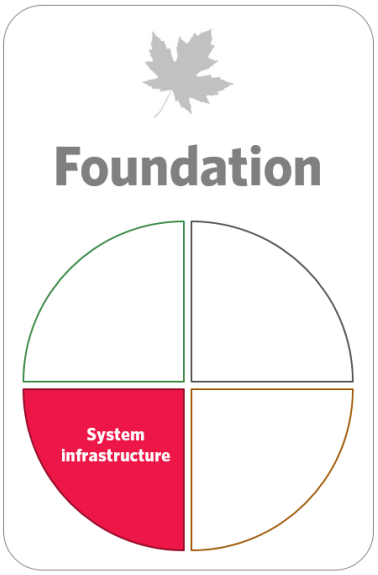
ACP funding for general practice



What: How to incorporate ACP into an existing model of care

Why/rationale: Historically eligible patients with very high and complex health conditions currently received funding through Care Plus. Client Led Integrated Care (CLIC) is a new model of care which incorporates ACP to allow eligible patients to have ACP conversations with health care professionals.

Who: Southern DHB

Benefits/value added:

- Patients with very high health care needs are identified for ACP conversations and are able to express their wishes and preferences for their future health care.
- Eligible patients do not have to pay for consultations with health care professionals.

Risks/challenges:

- Linkage to Care Plus funding is not approved by DHB executive.
- Care Plus data is not captured accurately to allow stratification of patients.
- Patient do not want to have ACP conversations.

Steps: How this looked on the ground

1. Met with Planning & Funding Portfolio Manager for Health of Older People who has Long Term Chronic Conditions as part of their portfolio and/or the Long Term Conditions Alliance Leadership team or DHB executive with Long Term Chronic Conditions responsibilities.
2. Considered funding streams for Long Term Chronic Conditions and how this could be utilised for delivering ACP to people (eg, Care Plus or similar funding for patients with comorbidities).
3. Consider stratifying the complexity of need of patients within a Long Term Conditions profile with a focus on those with high and very high complex needs.
4. Engage with primary care / general practice to determine pilot sites.
5. Encourage staff within these general practices to complete Level one eLearning and additional ACP training.
6. Identify patients who have high and very high and complex needs and encourage general practice to consider offering ACP as part of the care plan which offers eligibility to Care Plus funding.
    - Practices assess patients, assisted by a comprehensive health assessment on WellSouth portal.
    - Patients are stratified into 1 of 3 levels.

- Funding is linked to the level.
- A standard package of care for each level is delivered, by a practice as it sees fit:
    - comprehensive assessment
    - care plans – levels 2 & 3 include ACP
    - multi-disciplinary meeting.

Future opportunities:

- Next steps to undertake financial modelling for implementation across Southern.
- General practices integrate ACP into other cohorts of patients' care planning.

Impact:

A case example

Mrs Smith, 82-year old lady with type 2 diabetes, needing to start insulin and has COPD. Lives alone and has frequent admissions to hospital.

Old programme

Mrs Smith would have up to 4 Care Plus visits per year (subsidised) either with GP or practice nurse depending on practice. Management plan by the respiratory team following admission, no integrated care plan and management of LTC happening in silos.

New programme

Mrs Smith has been identified on the risk prediction tool as 87% chance of hospitalisation in the next 12 months, a comprehensive health assessment has been undertaken by practice nurse and Mrs Smith has been stratified as a Level 3 package of care. She will have an acute plan developed, a personalised care plan, an advance care plan and a multidisciplinary team meeting to ensure input from all services involved in Mrs Smith's care. She is over 75 so will also qualify for the HOP wrap around support to assist her to remain in her own home as long as possible

Similar examples from others:

31.0 CDHB – Subsidy for general practice