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## CONFERENCE ABSTRACT

### A person centred care plan – or a plan for patient care?

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**Introduction:** Counties Manukau Health (CMH) delivers services to an ethnically diverse population, including a high proportion of our indigenous population, high rates of deprivation and people with complexity in terms of multiple long term conditions and social disadvantage. A change in culture of how we engage with individuals, their families and community was needed to ensure a truly person centred approach with the ability to address the social determinants of health to improve health outcomes. This change in culture has been developed by ensuring we ask people “what matters to you – rather than what is the matter with you”

**Method:** Developed from extensive stakeholder input from primary and secondary care, CMH implemented an E-shared care plan format used across the system to support patients with complex needs. The essence of the approach is the person centred care plan, developed in partnership with the individual, and as appropriate with their families, within the E-shared Care system. This is shared electronically with the health care providers that the individual agrees to have on their health care team. People enter the process with a willingness to change and work towards their goal, supported by interventions tailored to meet their individual needs. The care plans have common headings including About Me; My Goal(s); What I will do; What my health care team will do as well as Wellbeing from a cultural/spiritual and social integration aspect, Lifestyle and Daily activities, and Early Warning Signs and how I can best respond. The system also has an e-health record summary, medicines list, and clear visibility of who is on the person’s health care team.

Incorporated into the process is a named coordinator which is visible across the system, use of standard assessments for different patient cohorts such the Flinders Partners in Health Scale for people with long term conditions, and access to appropriate funding streams to support patients to achieve their goal within a financial reality.

Individuals access their care plan via the patient portal and can invite family onto their care team. The care plan is visible across the health system for relevant clinicians and includes a tasking and messaging function to minimise the need for traditional referral processes and ensure clarity of roles and responsibility.

**Impact:** Early evaluation for this approach within CMH has shown improved patient engagement, improved health literacy and self management capacity, reduced incidence of non attendance at health appointments, increased support of the patient’s goal during all health interactions and reduced mixed messages from health professionals. Success for this approach

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requires a change of hearts and minds and despite some initial resistance the feedback from the Learning Collaboratives has shown acceptance of this innovative, person-centred and flexible approach to improve health outcomes. To date CMH has over 15,000 patients with a person centred care plan within the E-Shared care system.

**Discussion:** While there is now agreement that person-centred care is effective at improving health outcomes, the systematic implementation of this approach in a large population has been limited. Counties Manukau Health, through collaboration across all health care providers and utilisation of information technology, has implemented this successfully and will continue to be able to evaluate the effect on improving equity for a high needs population.

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**Keywords:** person centred; goal based; care planning; care co-ordination; long term conditions

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