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CONFERENCE ABSTRACT

# Enabling intra-DHB patient-specific care for patients with intestinal failure

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Patients with intestinal failure are medically fragile and need timely intervention when and wherever they present. Care is often fragmented across the care settings e.g. Starship (tertiary), DHBs (secondary) and GPs (primary) due to poor information systems interoperability. Patients want to be cared for in their own communities with the ability to access specialist care.

The National Intestinal Failure Service's connected care pilot supports patients with intestinal failure to have care delivered in their own DHB, while building local skills and capability. Patient-centred multidisciplinary intra-DHB teams, working in a virtual environment with patient-specific shared care plans provide care to patients in Hutt and Hawkes Bay DHBs.

To improve patient safety and empower patients to self manage, relevant information must be easily and securely available to the patient, their whanau/family and multi-disciplinary team. An e-shared care solution was designed to place the patient and whanau at the centre of their healthcare, transforming their experience within the healthcare system in line with Simon Sinek's Golden Circle communication model.

Whanau Tahi Connected Care (WTCC) supports a secure shared care plan, accessible via mobile devices, and integrated within existing hospital systems such as Concerto. This enables the development of a personalised electronic care plan which is comprehensive and supports coordination of care in partnership with patients. The Shared Care snapshot summary allows clinicians providing acute care to view important and relevant clinical information e.g. allergies, diagnosis, medications, care plans and previous decisions. Each patient has a care coordinator, in this case either a community nurse or clinical specialist.

The pilot began in late 2015 and is receiving positive interest from other DHBs who are managing patients with intestinal failure, for its potential to remove the barriers to equitable access and integrated healthcare provision through teamwork across healthcare environments.

WTCC is available as a service and does not require additional on-site implementation. Already used throughout Auckland DHB and endorsed as the National Shared Care platform, WTCC can be easily extended to other DHBs as necessary.

By mid-2016, approximately 20 children have shared care plans and 20 adults have been enrolled with shared care plans being developed. One to one training is provided by an ADHB trainer as each

patient, family/whanau joins the pilot. In addition, WTCC's scheduling and task management features are being applied to support some 30 other families.

It is anticipated that the health care experience of patients and their family/whanau will improve over time as processes are tested, evaluated, refined and embedded in practice. This includes developing strategies to address perceived potential barriers to adopting a shared care such as computer/device literacy and patient and family/whanau discomfort with reliance of technology to access healthcare.

One of the insights from the pilot is that the needs of patients with long term health conditions change as they age and electronic shared care plans should adapt as people transition through their lifespan and also across care settings. For example, enabling privacy settings to change as teens mature into adults and rely less on their parents.

**Keywords:** intra-dbh virtual teamwork; integrated care; personalised care plan; starship