## Patient Centered Health Services Delivered in Community Settings

| Patient complexity | General Practice provided care | RAPHS Extended Care Support Team involvement - making every contact count |
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| **Level 1 - All non-complex patients with routine episodic care**<br>• Patients with a Low LINC score<br>• 50% LINC patients<br><br>All patients with a long term condition should be should be enrolled in LINC<br><br>Care delivered within first level and LINC funding | **Patient activity led within the practice by the General Practice Team -** Annual patient review and care plan with General practice led lifestyle education and support to enhance patient self-management<br>• More heart and diabetes checks<br>• Smoking cessation<br>• Living well with Diabetes<br>• Healthy Women<br>• Respiratory health-<br>• Healthy Men<br><br>Consider the need for community provider involvement and patient education such as referral to:<br>• GreenRx<br>• Community Pharmacy | **RAPHS Extended Care Support Team** can provide:<br>• One off clinics within your practice to help meet demand<br>• Workforce training and support for new staff<br>• Advice and guidance around community services which may be appropriate |
| **Level 2 - All patients with moderate complexity who require routine care at regular intervals, likely to be:**<br>• Patients with a moderate LINC score<br>• Approximately 25% of LINC patients<br><br>**Or**<br><br>**All patients who have an increased risk of hospitalization or readmission following discharge from hospital**<br><br>**Or** | **Patient activity led within the practice by the General Practice Team -** General practice extended care consult and six monthly patient review to undertake and develop a:<br>• Personal Health Assessment<br>• Plan of care<br>• Exacerbation plan<br><br>**General practice to refer to RAPHS Extended Care Support Team if help required**<br><br>**General practice to refer to Whanua Ora or to the appropriate DHB community Allied Health service via the appropriate eReferral**<br>• Community Dietitian | **RAPHS Extended Care Support Team** can provide:<br>• Regular clinics within your practice to meet short term capacity and capability issues<br>• If required referral coordination to:<br>  ○ Whanau Ora<br>  ○ Community Dietitian<br>  ○ Community Physiotherapy<br>  ○ Community Social Work<br>  ○ Community Pharmacy – MuR and LTC management<br>  ○ Other appropriate community providers<br>• Prevention of admission (POAC) and readmission consults on your behalf if required<br>• Other POAC services for your patients who may find it difficult to access their general practice. |

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| **All patients who are eligible for the following POAC services**<br><br>• DVT<br>• Renal Colic<br>• Prevention of readmission<br>• Cellulitis<br>• Sore Throat<br>• Correction of dehydration<br>• Insulin Initiation<br><br>Care delivered within first level and LINC funding and practices have access to packages of care and POAC funding | • Community Physiotherapy<br>• Community Social Work<br>• Community Pharmacy – MuR and LTC management<br>• Another appropriate community provider<br><br>When a patient meets eligibility criteria for POAC service, practice delivers service, codes activity and completes a discharge summary | |

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| **Level 3 - All patients with a high complexity who require expert care at regular intervals, likely to be:**<br>• Patients with a High LINC score<br>• Approximately 15% of LINC patients<br><br>Care delivered within first level and LINC funding and practices have access to packages of care and POAC funding | **Patient activity led within the practice by the General Practice Team -** General practice extended care consult with up to four patient reviews to undertake and develop a:<br>• Personal Health Assessment<br>• Plan of care<br>• Exacerbation plan<br><br>General practice to refer to RAPHS Extended Care Support Team to gain access to ongoing management and access to specialist services such as:<br>• Expert Nurse<br>• Nurse Practitioner<br>• Clinical Pharmacy<br>• Care coordination of complex patients<br>• Access to wider community support and/or the DHB community Allied Health service | **RAPHS Extended Care Support Team can provide:**<br>• Expert clinical care and care coordination of complex patients via regular clinics in your practice or at RAPHS<br>• Access to Clinical Pharmacy advice<br>• Outreach visits on your behalf<br>• Access to wider community support and/or the DHB community Allied Health service<br>• Coordinated access to specialist services for complex patients such as:<br>  ○ Whanau Ora<br>  ○ Heart failure clinic<br>  ○ Diabetes service<br>  ○ Pre-op service<br>• Facilitate access into General Practice for complex patients when referrals are received from: |

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| RAPHS involvement provided free of charge to practice and patient | All referrals to include:<br>• Access to ProvideWise<br>• Reason for referral<br>• Current Medications<br>• Diagnosis list<br>• Most recent labs: HbA1c/Electrolytes/s. creatinine/CBC/ACR and MSU/TFTs/LFTs/Lipid profile (maybe non fasting and type 1) | ○ Whanau Ora<br>○ DHB secondary services<br>▪ facilitated access to specialist services for complex patient<br>▪ facilitated discharged from hospital for complex patients<br>○ Other community services as appropriate<br><br>All patients will be managed to a point where they can be safely handed back to general practice for ongoing care. |

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| **Level 4 – All patients with a high complexity who require advanced health assessment and diagnostic decision making, likely to be:**<br>• Patients with a High LINC score<br>• Approximately 10% of LINC patients<br><br>Care delivered within first level and LINC funding and practices have access to packages of care and POAC funding<br><br>RAPHS involvement provided free of charge to practice and patient | **Patient activity led within the practice by the General Practice Team -** General practice extended care consult with up to four patient reviews to undertake and develop a:<br>• Personal Health Assessment<br>• Plan of care<br>• Exacerbation plan<br><br>**General practice to refer to RAPHS Extended Care Support Team for Coordination of referrals to specialist care and community care including Whanua Ora.**<br><br>All referrals to include:<br>• Access to ProvideWise<br>• Reason for referral<br>• Current Medications<br>• Diagnosis list | **RAPHS Extended Care Support Team will provide a service for practices to utilise when they require extra capability and capacity to undertake advanced health assessment, care planning and diagnostic decision making via regular clinics in your practice or at RAPHS.**<br><br>Development of:<br>• Personal Health Assessments<br>• Plans of care<br>• Exacerbation plans<br>• Care coordination and case management via regular clinics in your practice<br>• Access to a wide multidisciplinary care team and wrap around services<br>• Outreach visits on your behalf<br>• Regular MDT meetings<br>• Coordinated access to specialist services for complex patients such as: |

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| | • Most recent labs: HbA1c/Electrolytes/s. creatinine/CBC/ACR and MSU/TFTs/LFTs/Lipid profile (maybe non fasting and type 1) | ○ Whanau Ora<br>○ Heart failure clinic<br>○ Diabetes service<br>○ Pre-op service<br>• Facilitate access into General Practice for complex patients when referrals are received from:<br>○ Whanau Ora<br>○ DHB secondary services<br>▪ Oversight of complex patients discharged from Lakes DHB who require further support to remain at home<br>▪ Oversight of complex patients receiving ongoing DHB specialist services<br>• Access to other community services as appropriate<br><br>Patients will be managed to a point where they can be handed back to general practice for ongoing care.<br><br>• Workforce development support within your practice |