Welcome from Dunedin, New Zealand

Organisations and Driving Principles

- Quality Improvement
- Cost Reduction/containment
- Best Practice Advocacy
- Education
- Multidisciplinary working
- Standards and Guideline development & uptake
- Promoting Primary Care

New Zealand or Aotearoa

- lies in the southwest Pacific Ocean to the east of Australia
- 4.51 million people, predominantly of New Zealand European ethnicity (74.0%), with significant Maori (14.9%), Pacific (7.4%), Asian (11.8%)
- Only 5.4% of Maori are aged 65 years and over, compared to 14.3% overall

Health System

- predominantly publicly funded, universal coverage health system
- government funded 82.7% of national health care expenditures in 2012, with the remaining 17.3% paid by individuals
- public expenditure on health care was equivalent to 10.3% of GDP, just above the OECD average of 9.3%
- Private health insurance payments account for only 4.9% of national health expenditure
- Life expectancy at birth 79.3 years for males and 83 years for females.
- Marked ethnic differences in life expectancy. 76.5 years for Maori females, 72.8 years for Maori males, 83.7 years for non-Maori females and 80.2 years for non-Maori males

NZ Triple Aim

SPECIALIST CARE TREATMENT
SPECIALIST HOSPITALS
Something had to change.
LOCAL AMBULANCE
PHARMACY
SERVICES
CLEAN AIR & WATER
RURAL HOSPITALS & COMMUNITY HUBS
SPECIALIST MENTAL HEALTH
TECHNOLOGY
LMC
DENTAL
CONNECTED COMMUNITIES
DIRECT ACCESS
PEOPLE CENTRED
YOUR HEALTH
LIBRARY
VOLUNTEER SERVICES
COMMUNITY MENTAL HEALTH
PATIENT PARTNERSHIP
A fierce & ageing workforce
LAB SERVICES
COMMUNITY REFERRED RADIOLOGY
Isolated General Practice
CONSULTANT
HOME
WHANAU ORA
GENERAL PRACTICE
COMMUNITY NURSING
MORE LOCAL SERVICES
FAST TRACK
GP SERVICES
health system

Aging and Multimorbidity

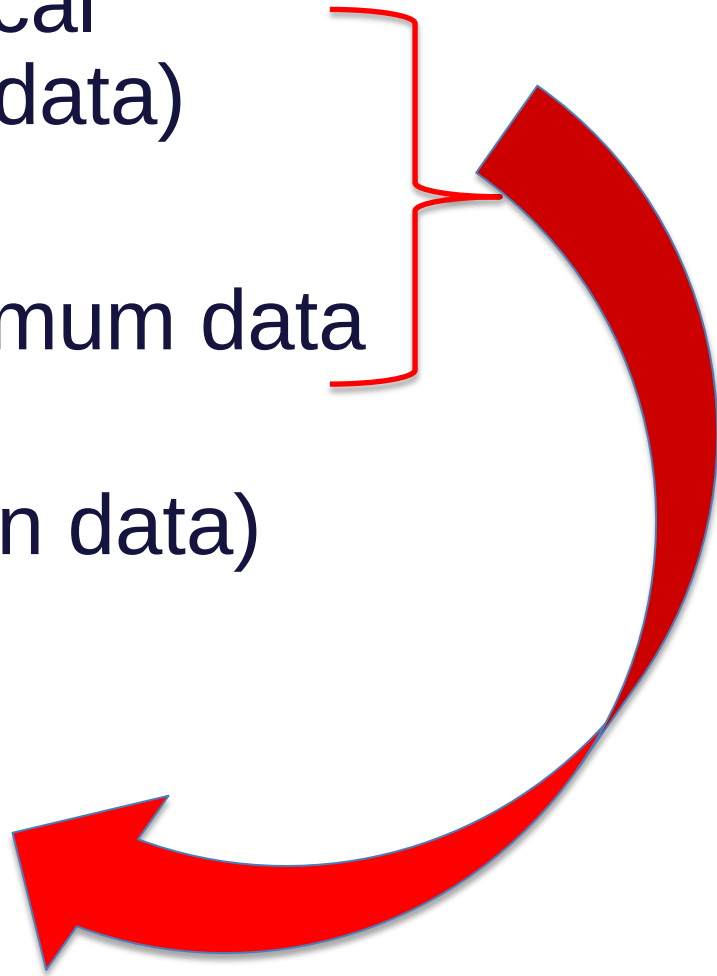
A major challenge for healthcare systems

- Ageing populations
- Increasing long-term conditions
- Increasingly complex and intensive
- Care is more specialist and fragmented

Methods – datasets

2013

- New Zealand Pharmaceutical collection (pharmaceutical data)
- Primary Care data set
- New Zealand national minimum data set (hospital data)
- NZ Census data (population data)

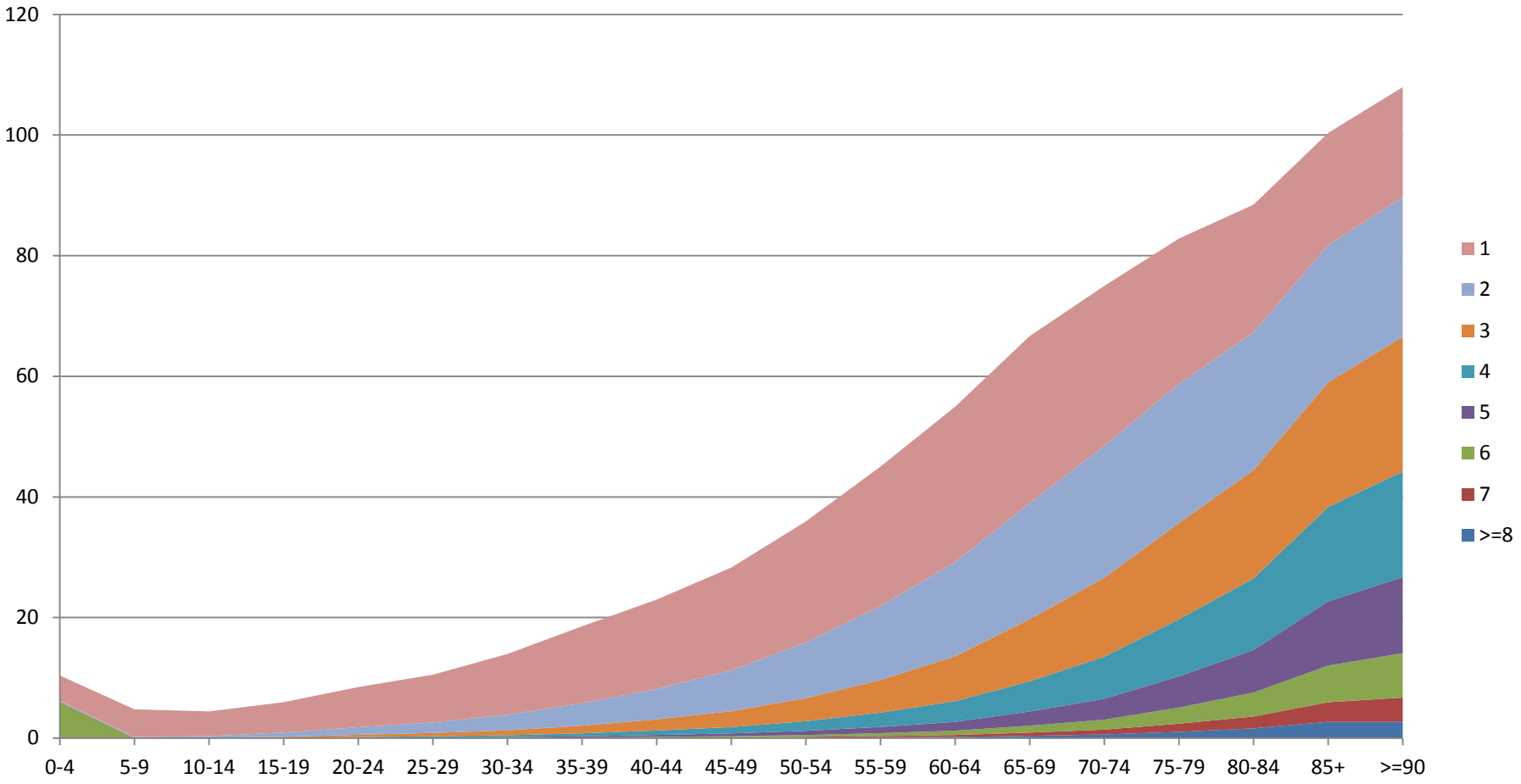


Can be linked through National Health Index

Results

- 35% (1,557,921) of NZ population had a chronic condition (range 1-15)
- 20% had at least 2 chronic conditions
- The most common chronic condition was pain (n=742,527)
- The number of chronic conditions increased with age

Multimorbidity increases with age

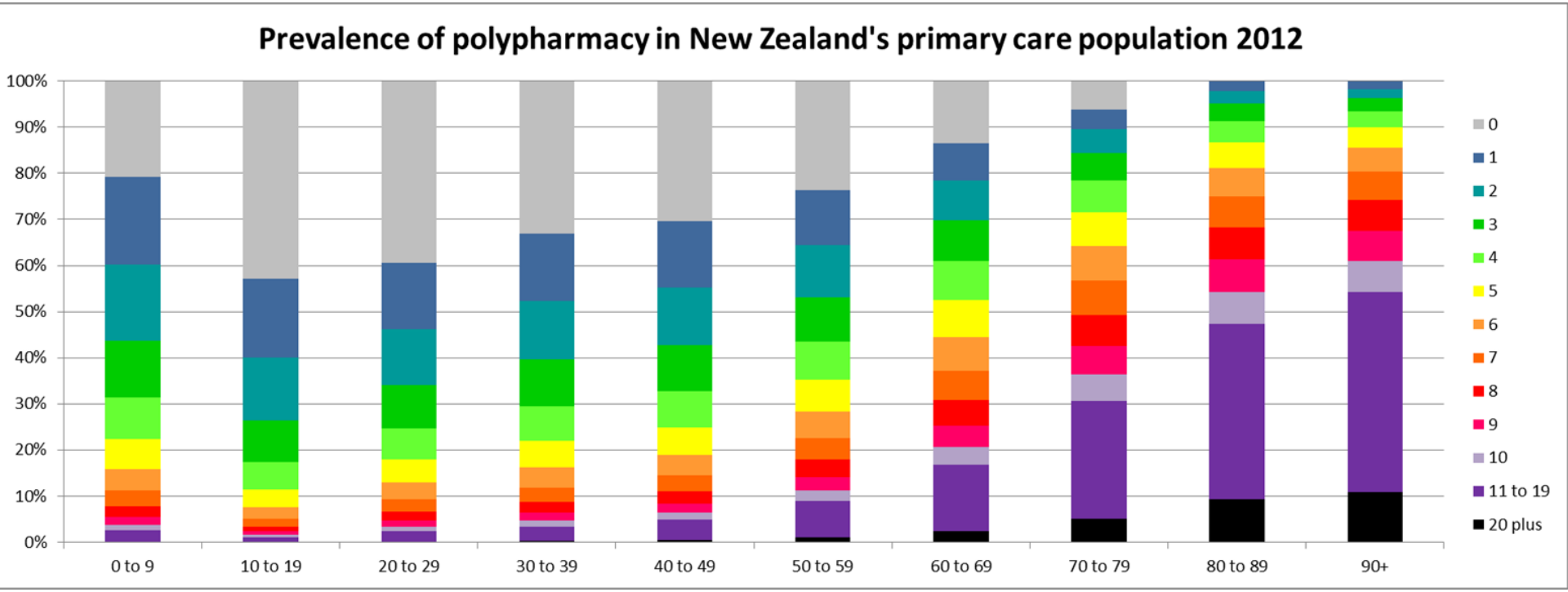


Combinations

The percentage of people with the row condition who also have the column condition

	Pain	Hypertension	Dyspepsia	Depression	Asthma	Diabetes	CHD	Thyroid	Constipation	Epilepsy
Pain		32	20	13	9	8	6	5	9	4
Hypertension	36		27	13	10	18	13	8	9	5
Dyspepsia	52	63		21	14	14	15	9	14	9
Depression	40	35	24		10	8	6	7	10	12
Asthma	34	34	20	13			7	5	6	5
Diabetes	39	75	25	13	10		12	7	8	5
CHD	44	83	42	15	13	18		9	14	7
Thyroid	35	50	25	17	10	12	9		10	7
Constipation	26	57	42	26	13	13	15	10		18
Epilepsy	53	36	26	30	10	9	7	7	18	

Results - Polypharmacy



In Summary

- Mulitmorbidity and polypharmacy are increasing
- Multimorbidity is ‘caused’ by survivorship;
- Polypharmacy is ‘caused’ by the existence of multiple effective treatments

Real time data

Population	Eligible	5 or Less	6-10	11-15	16+
High Needs	156	141	14	1	0
Total Population	1211	1127	80	4	0

Multiple Prescribers

7 prescribers - 20 drugs

Dr B	Amitriptyline
Dr F	Amoxycillin Clavulanate
Dr A	Aspirin
Dr A	Aspirin
Dr B	Ciprofloxacin
Dr G	Codeine Phosphate
Dr G	Flucloxacillin Sodium
Dr D	Fluticasone
Dr E	Fluticasone
Dr A	Glucagon Hydrochloride
Dr B	Hydrocortisone with Miconazole
Dr G	Hydrocortisone with Miconazole
Dr A	Insulin Isophane with Insulin Neutral
Dr G	Omeprazole
Dr B	Paracetamol
Dr B	Prednisone
Dr F	Prednisone
Dr A	Quinapril
Dr A	Quinapril
Dr G	Quinapril with Hydrochlorothiazide
Dr D	Salbutamol
Dr E	Salbutamol
Dr E	Salbutamol
Dr C	Salbutamol with Ipratropium Bromide
Dr A	Simvastatin
Dr A	Simvastatin
Dr A	Thyroxine
Dr A	Thyroxine
Dr E	Warfarin Sodium

Real regimen, dispensed October 2014

Future directions

- What strategies to primary care providers have for choosing therapies that optimize benefit, minimize harm, and enhance quality of life for older adults with multimorbidity?

- Guidelines/Pathways ?
- Medication reviews?

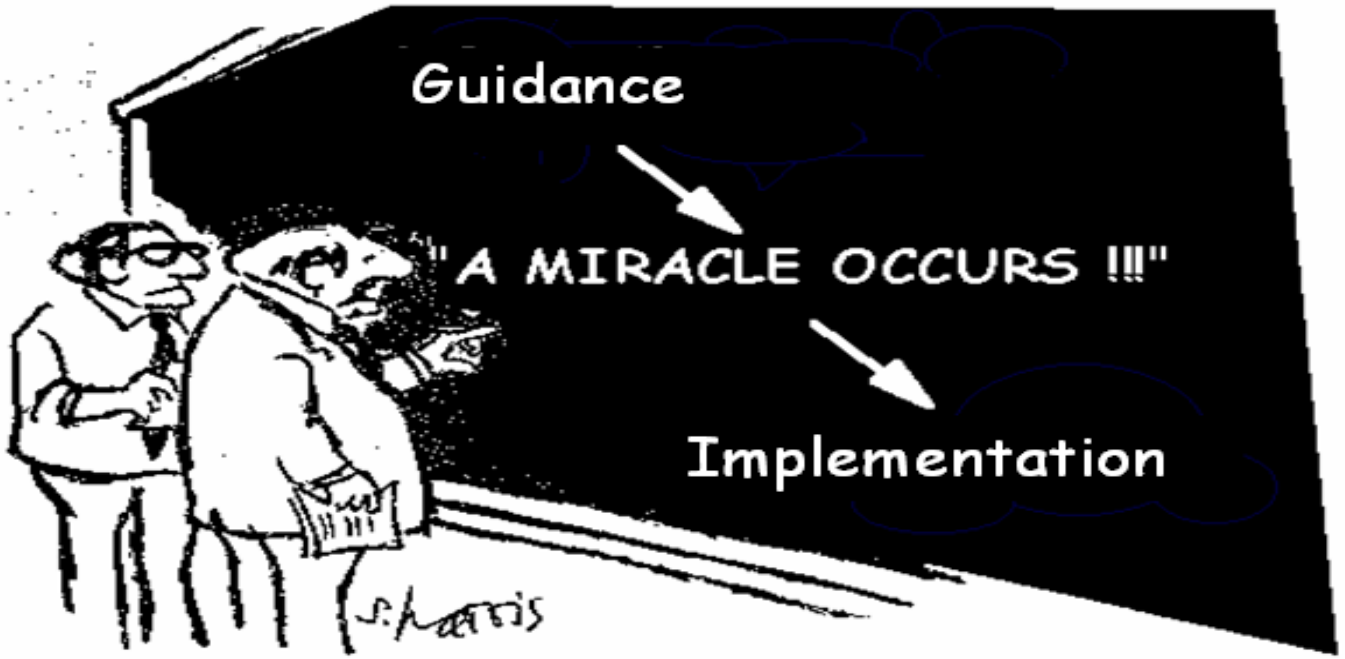
Guidelines and or Pathways

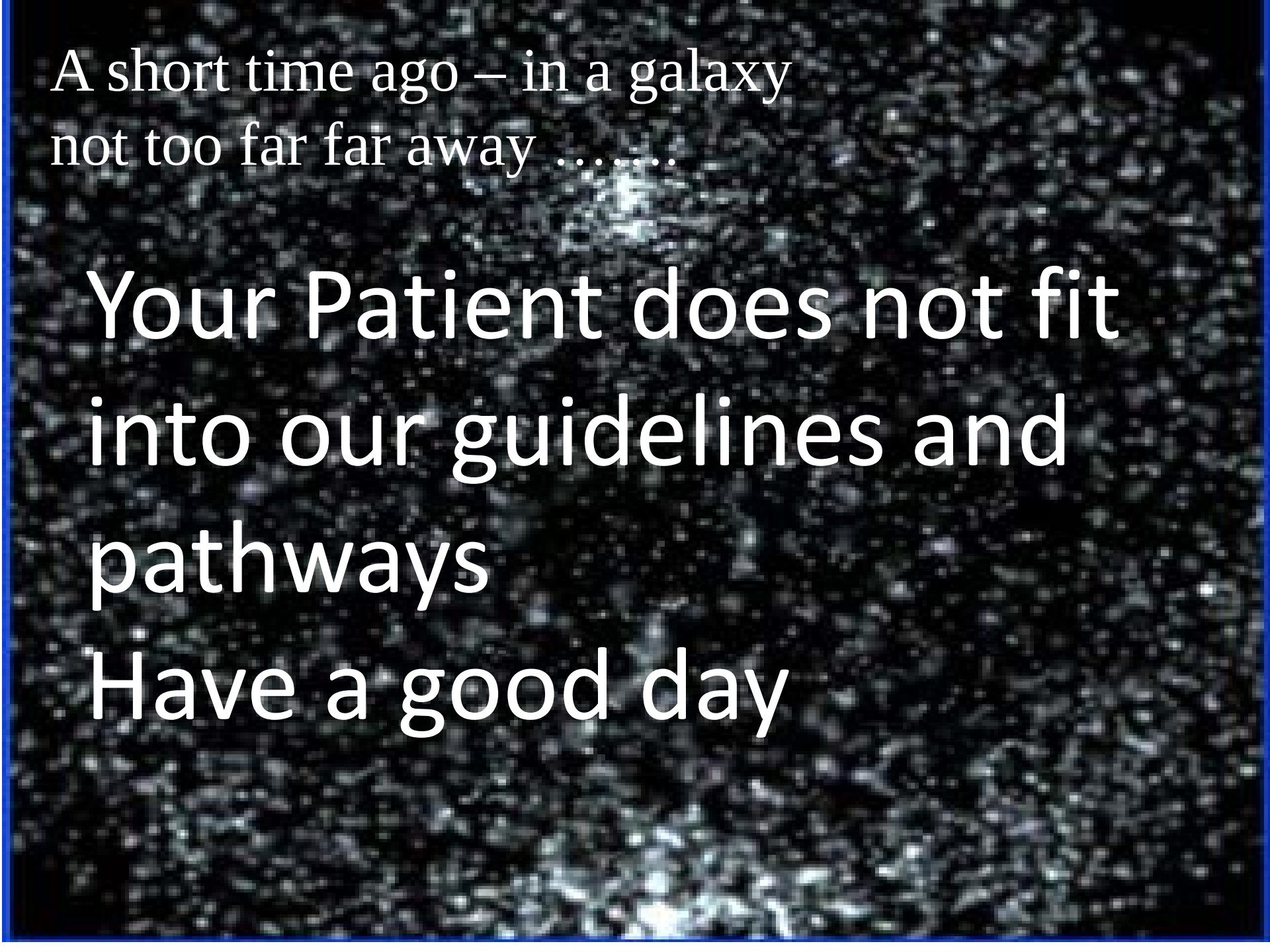
Are pathways different to guidelines

With guidelines, it was a bunch of people, usually hospital specialists sitting round a table, eating rubbery chicken sandwiches deciding what was good for us …

With clinical pathways you have people from both the hospital and general practice, all eating the same chicken sandwiches

Why don’t clinicians follow guidelines




A short time ago – in a galaxy
not too far far away ……
Your Patient does not fit into our guidelines and pathways
Have a good day

BEST PRACTICE
APRIL 2009
THE COMPLETE WORKS
20
best tests
best practice
TREATMENT OF GOUT
bpac nz
better medicine

Reliance on tools and information to inform clinical practice

Publication	Mean Score (the lower the score the more it is relied upon)
Best Practice DS tools	1.31
Best Practice Journal and website	1.65
Conference attendance	3.24
International Journals, e.g. BMJ	3.45
Peer advice	3.62
New Zealand Formulary	3.93
MIMS	4.03
CME sessions	4.24
New Zealand Medical Journal	4.43
Magazines, e.g. NZ Doctor, Pharmacy Today, Kaitiaki	4.70
Material provided by pharmaceutical companies	5.80

bpac^{nz} publications

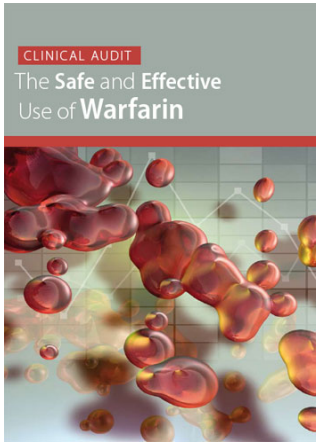
Best Practice Journal

- Evidence-based medical education for primary care clinicians
- First published October, 2006
- Eight editions per year; currently developing Issue 68
- Printed copies sent to 8500 healthcare professionals around New Zealand
- Full content online; over 1 million page views per year, 8000 registered users
- Contracted by PHARMAC + DHB Shared Services
- Each edition includes four main theme articles, editorial ‘Upfront’, ongoing series (e.g. high risk medicines), research news and correspondence
- Key characteristics are engaging, easy to read style, visually appealing graphics and practical relevance to primary care

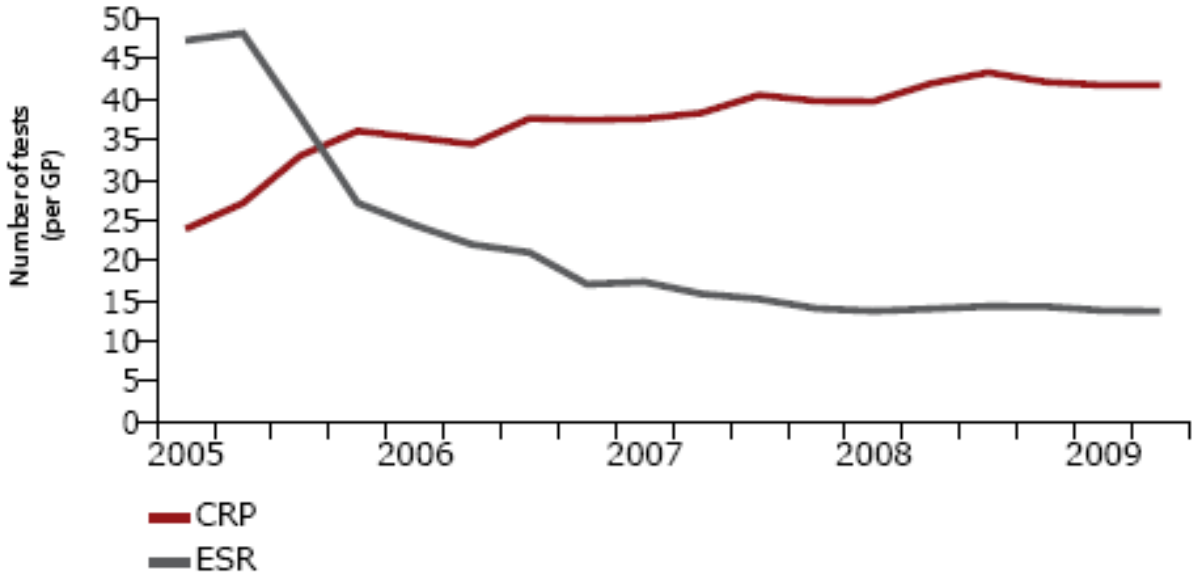
bpac^{nz} publications

- Best Tests
  - First published November, 2008
  - Four editions per year; currently developing Issue 27
  - Printed copies sent to 4500 general practitioners and pathologists
  - Contracted by DHB Shared Services
  - Two to three laboratory focused articles per edition

- **Reports and educational activities**
  - Eight themed prescribing and laboratory testing reports sent to clinicians each year + one annual report
  - Clinical audits available online
  - Interactive online quizzes and case studies



Focused Education



- **CRP vs ESR Assessing & Measuring the Inflammatory Response**
- **ESR ~ 68% decrease**
- **CRP ~ 54% increase**

Overall 29% decrease in total tests

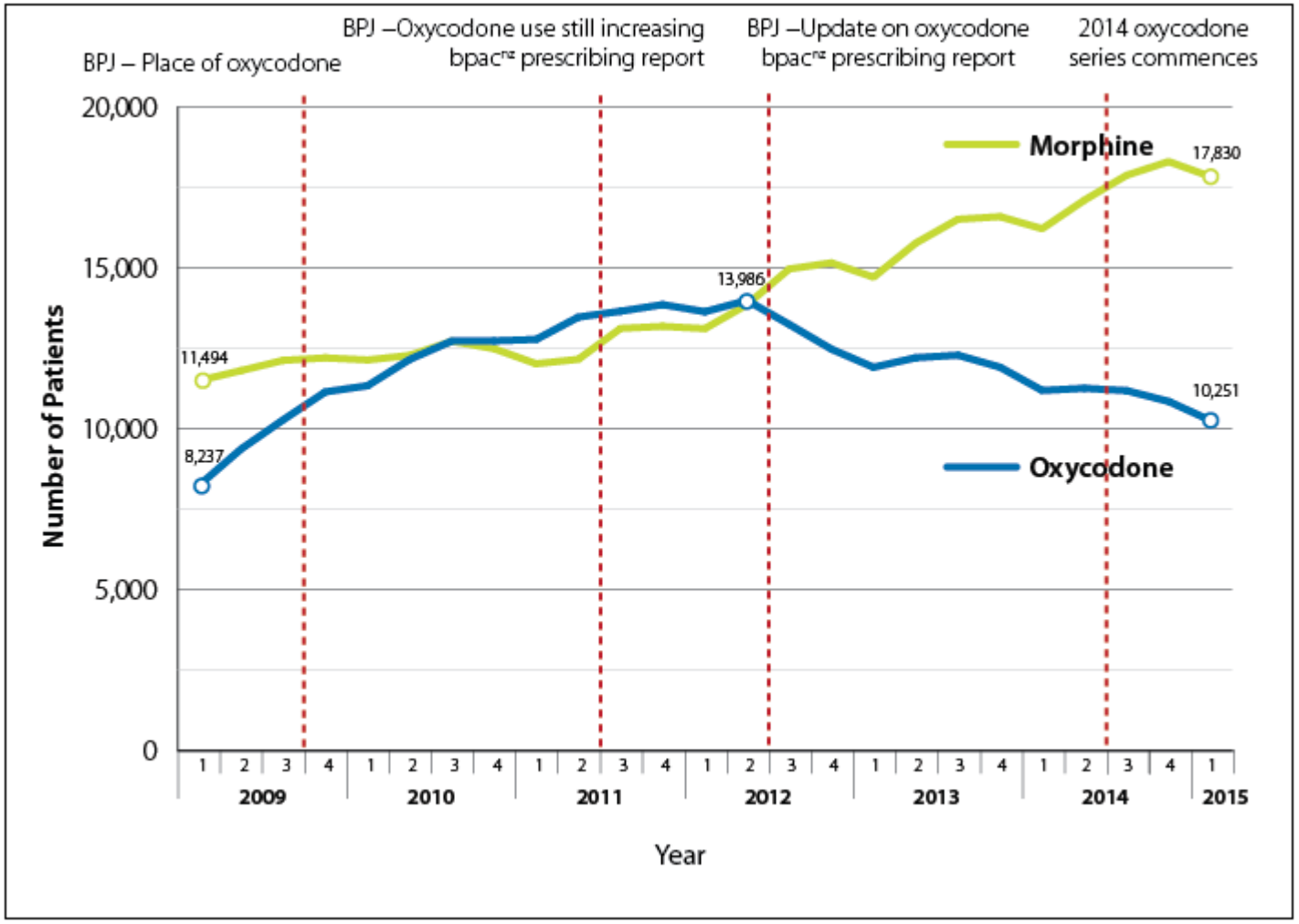
Focused Education

CRP vs ESR 2005 -2012

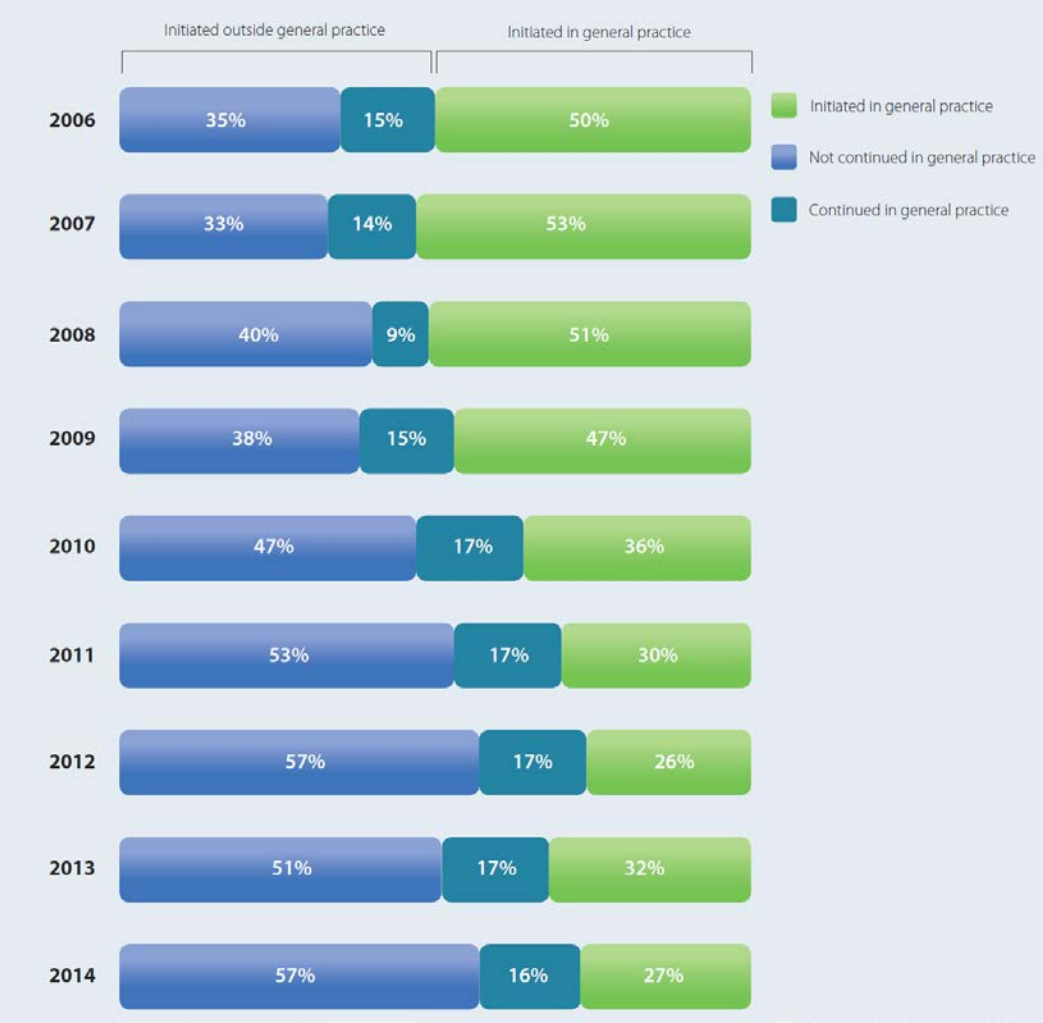
Combined total savings
> $17 Million

Cost of $1.5 million

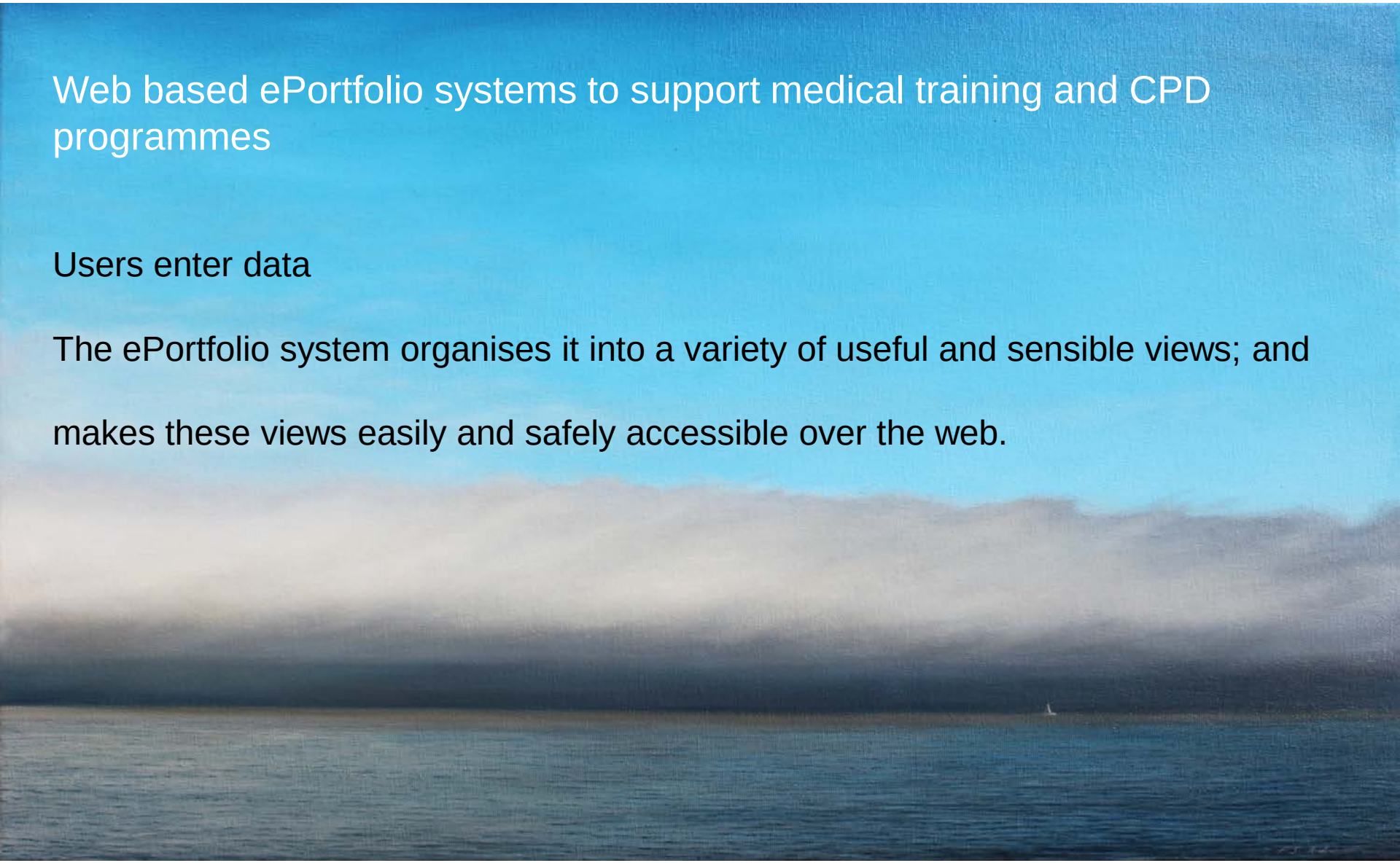
Oxycodone use



The **majority of oxycodone** is now initiated outside of general practice



Bpac ePortfolios



Web based ePortfolio systems to support medical training and CPD programmes

Users enter data

The ePortfolio system organises it into a variety of useful and sensible views; and

makes these views easily and safely accessible over the web.

in practice
RECERTIFICATION PROFESSIONAL DEVELOPMENT

ePort

bpac nz
better medicine

Bpac ePortfolios

Users create records by:

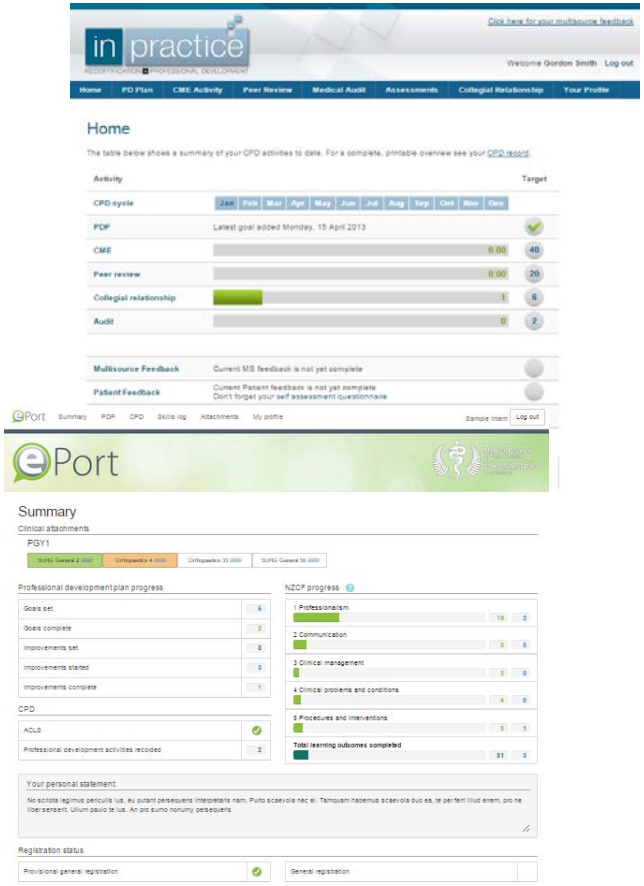
Entering information about activities they have completed

Scanning QR codes from events

Recording assessments of others directly into ePortfolios

Undertaking self assessments within the ePortfolio

Auto population when completing courses in external sites which link to the ePortfolio



in practice
RECERTIFICATION PROFESSIONAL DEVELOPMENT

ePort

bpac nz
better medicine

Bpac ePortfolios

Users share records through:

Peer to peer sharing of ePortfolios
Secure role based access to allow others to contribute to the ePortfolio by providing, reviews, comments and assessments

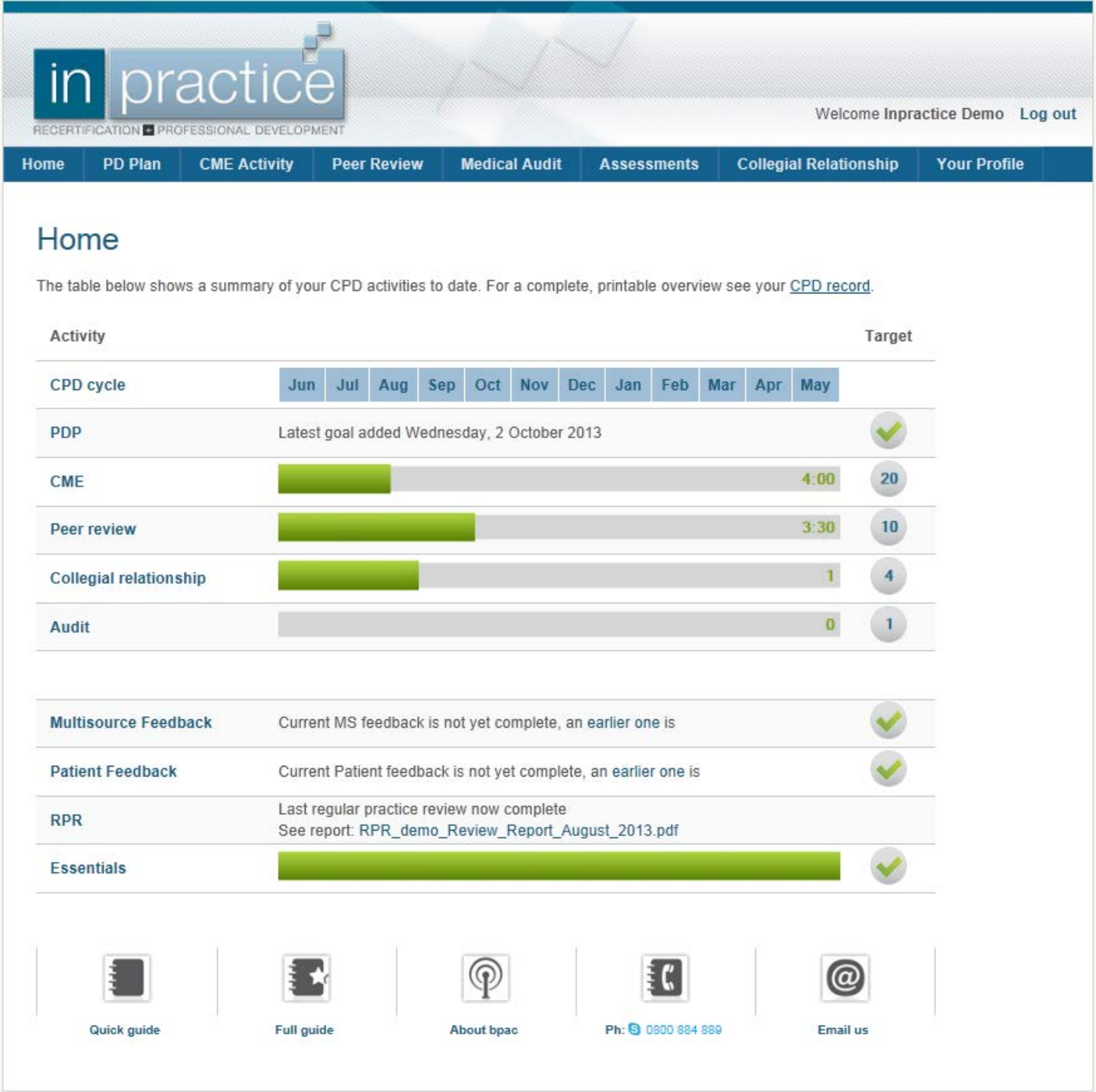
Access via secure login allows **role based access** that allows users to be in multiple roles e.g. Supervisor and examiner and event based roles e.g. end of programme assessment committees

Access via ePass provides **one off access** to specific areas of the ePortfolio e.g. Undertaking assessments or multisource feedback

in practice
RECERTIFICATION | PROFESSIONAL DEVELOPMENT

ePort

bpac nz
better medicine


in practice
RECERTIFICATION + PROFESSIONAL DEVELOPMENT
Welcome Inpractice Demo Log out
Home
PD Plan
CME Activity
Peer Review
Medical Audit
Assessments
Collegial Relationship
Your Profile
Home
The table below shows a summary of your CPD activities to date. For a complete, printable overview see your CPD record.
Activity
Target
CPD cycle
Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May
PDP
Latest goal added Wednesday, 2 October 2013
CME
4:00
20
Peer review
3:30
10
Collegial relationship
1
4
Audit
0
1
Multisource Feedback
Current MS feedback is not yet complete, an earlier one is
Patient Feedback
Current Patient feedback is not yet complete, an earlier one is
RPR
Last regular practice review now complete
See report: RPR_demo_Review_Report_August_2013.pdf
Essentials
Quick guide
Full guide
About bpac
Ph: 0800 884 889
Email us

ePort

Medical Council of New Zealand
Te Kaunihera Rata o Aotearoa

Summary

Prevocational educational supervisor(s):

Education Supervisor.

Clinical attachments

PGY1

SURG General 5 9999 | SURG General 2 9999 | Orthopaedics 4 9999 | SURG General 6 9999

Professional development plan progress

Goals set	3
Goals complete	1
Improvements set	7
Improvements started	2
Improvements complete	2

CPD

ACLS	✓
Professional development activities recorded	4

NZCF progress

1 Professionalism	19	0
2 Communication	3	0
3 Clinical management	4	1
4 Clinical problems and conditions	7	0
5 Procedures and interventions	5	1
Total learning outcomes completed	38	2

Your personal statement:

No scripta legimus periculis ius, eu putant persequeris interpretaris nam. Purto scaevola nec ei. Tamquam habemus scaevola duo ea, te per ferri illud errem, pro ne liber senserit. Ullum paulo te ius. An pro sumo nonumy persequeris

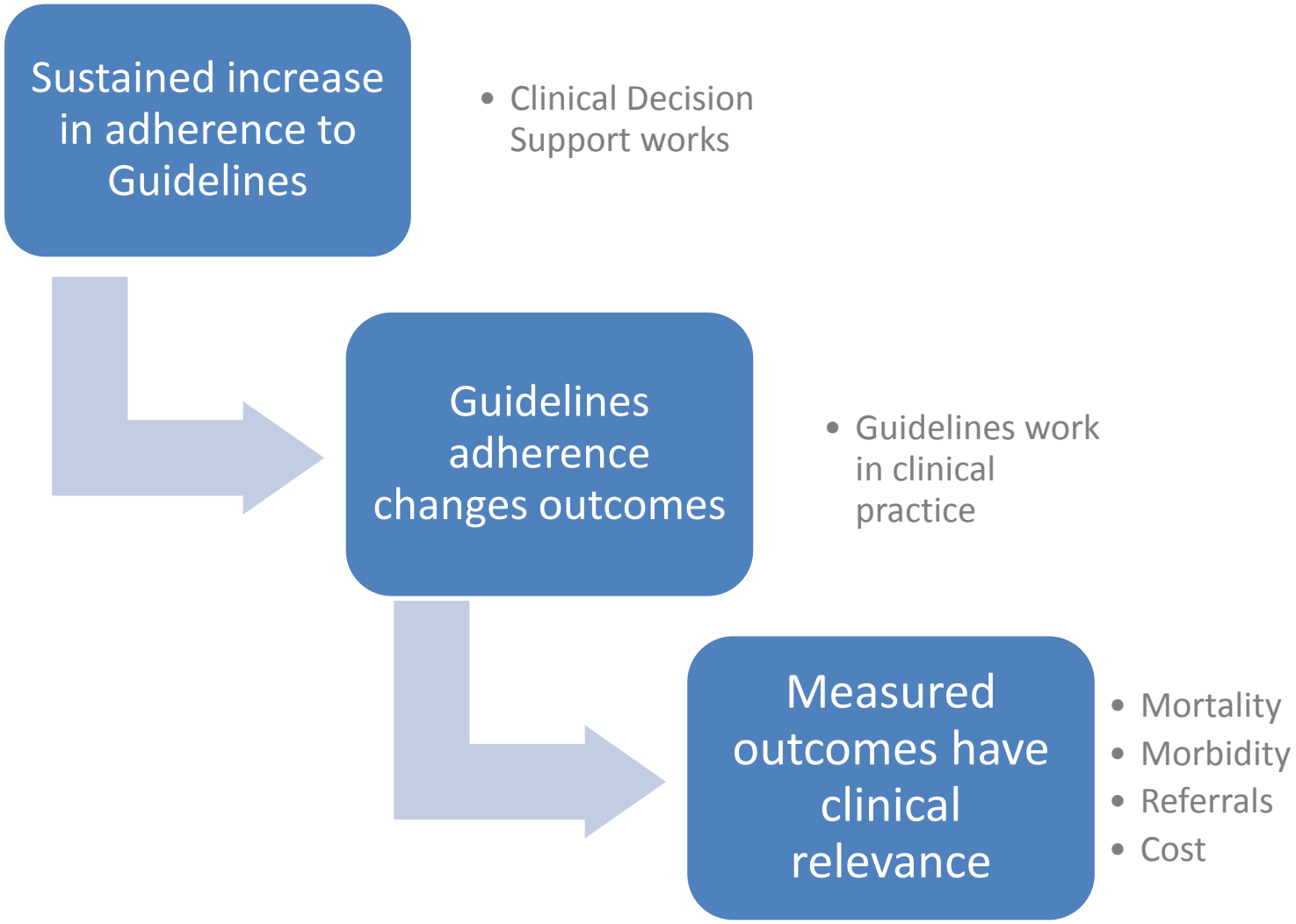
Issues for New Zealand (2005)

- 4 million patients, 1200 practices , lack of coordination , poor communication primary/secondary
- Facing aging population, increased complexity, multimorbidity, unsustainable cost increases
- Role General Practice /Role of Secondary care
- Primary care decision to invest in Decision Support 2005
- Aim for sustainability

Clinical Decision Support

- Right
  - Knowledge
  - Person
  - Provider
  - Care
- Improves and measures
  - Healthcare decisions
  - Health of individuals and populations
  - Outcomes

The Theory


Sustained increase in adherence to Guidelines
• Clinical Decision Support works
Guidelines adherence changes outcomes
• Guidelines work in clinical practice
Measured outcomes have clinical relevance
• Mortality
• Morbidity
• Referrals
• Cost

bestpractice care

NEW ZEALAND TODAY

Integrated into the standard workflow

Average of 140,000 hits per working day or 29.5 million per year

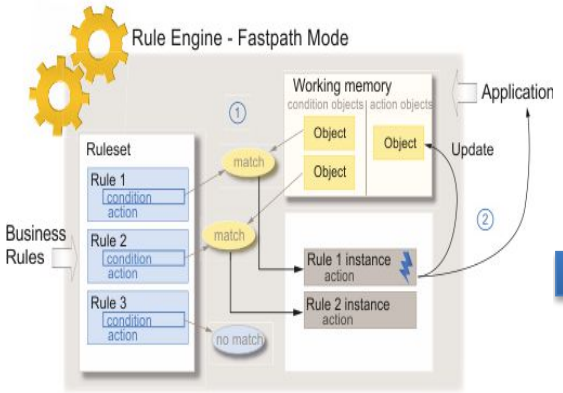
Used in 98% of practices

New Zealand Population: 4.5 million

Basic Principles

Guidelines or Pathways Care Information

Business Rules Engine



Guidelines Digitised on BPAC servers

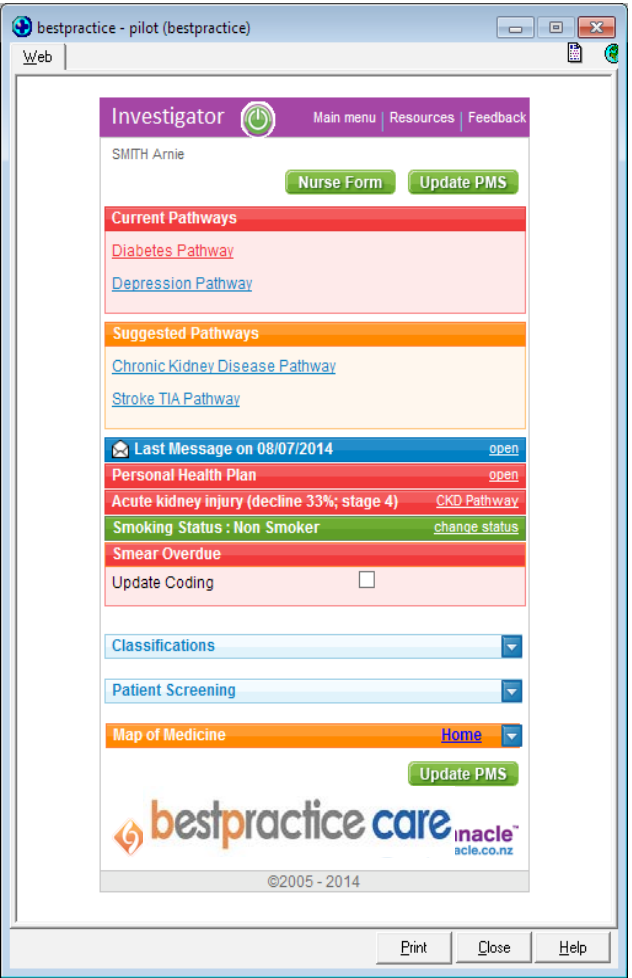
bestpractice care at a glance

Diagnosis Support

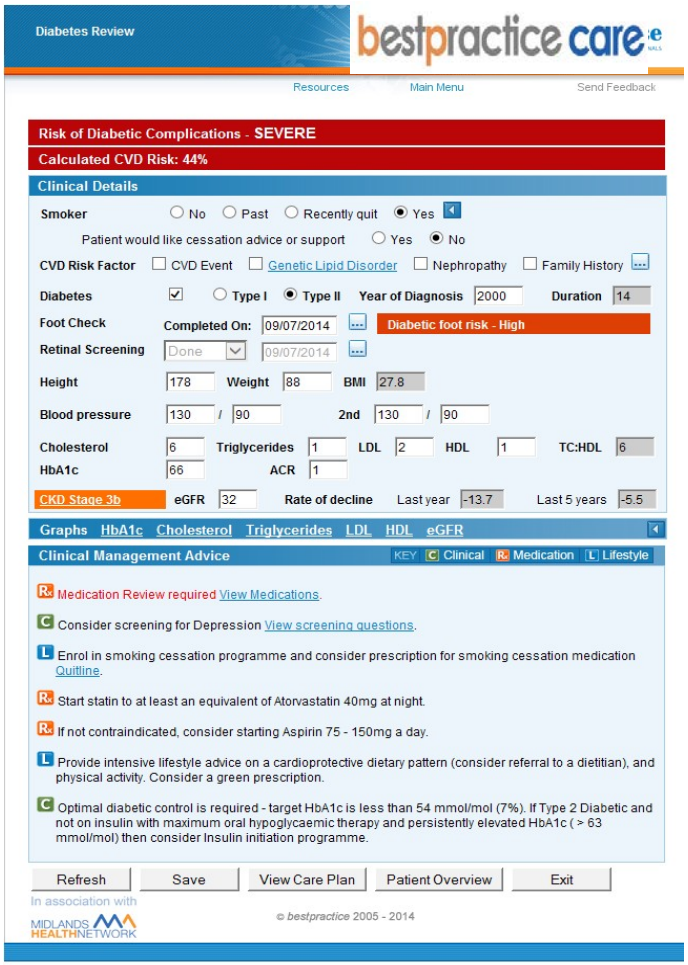
In-consultation Guidance

Referral Management

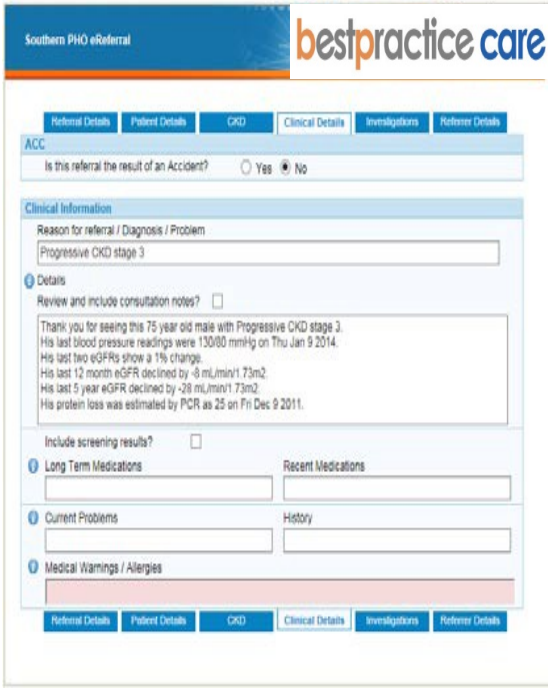
Patient Prompt



Clinical Modules



Intelligent Referrals



The Review Patient Prompt

Clicking this button saves all the data back into the patient record

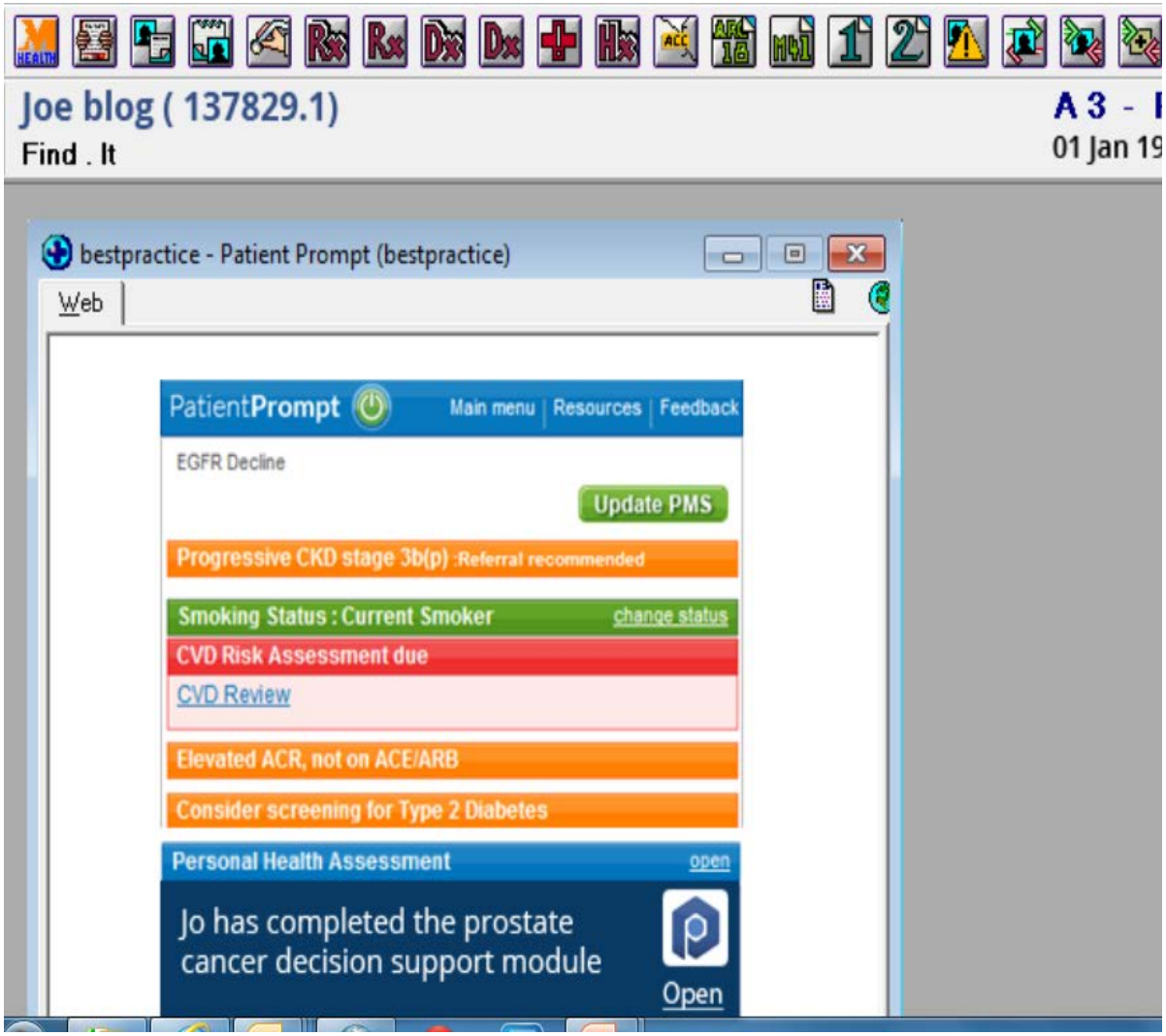
This patient is currently being treated on the diabetes and depression modules. Clicking the link opens the module.

Based on the patient's record, *pathways are* suggested. Here the patient is considered for the CKD and TIA modules

Based on data in the patient record and National guidelines classifications, coded messages and reminders are included here

Diagnoses (classifications) and basic examination data (eg BP or Weight) can be added here

Patient screening via web portal

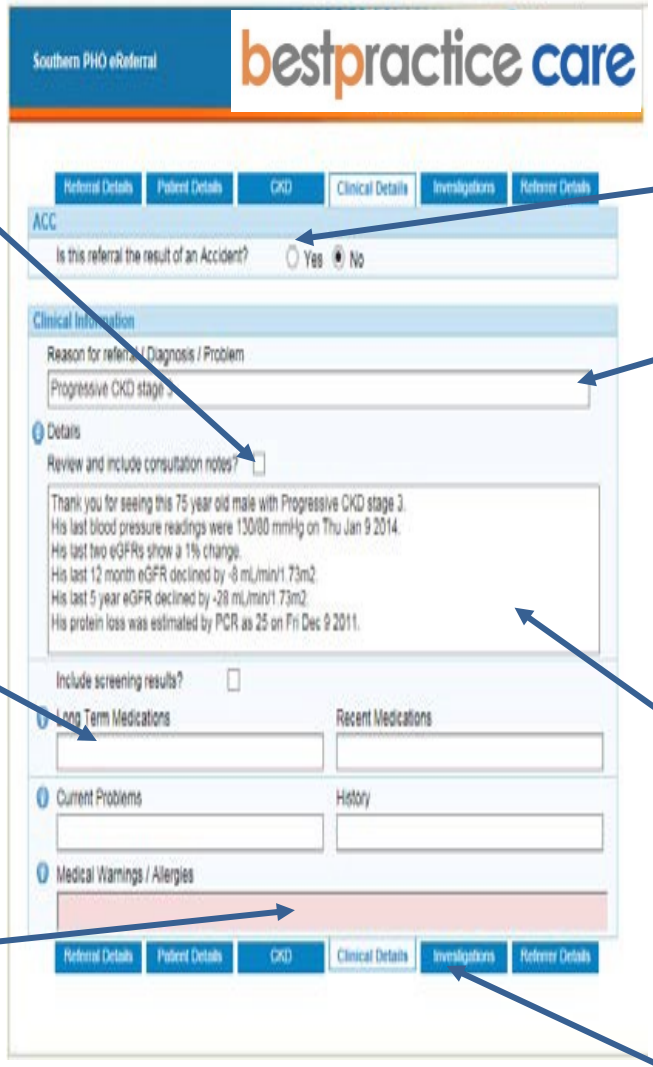


Referral guidance: Intelligent Referrals

Consultation notes can be added from the EHR.

Medications taken from the EHR

Medical warning and allergies added from EHR automatically.



Referral generation fully automated

Diagnosis pre-populated

Patient specific letter generated and prepopulated. Can be edited.

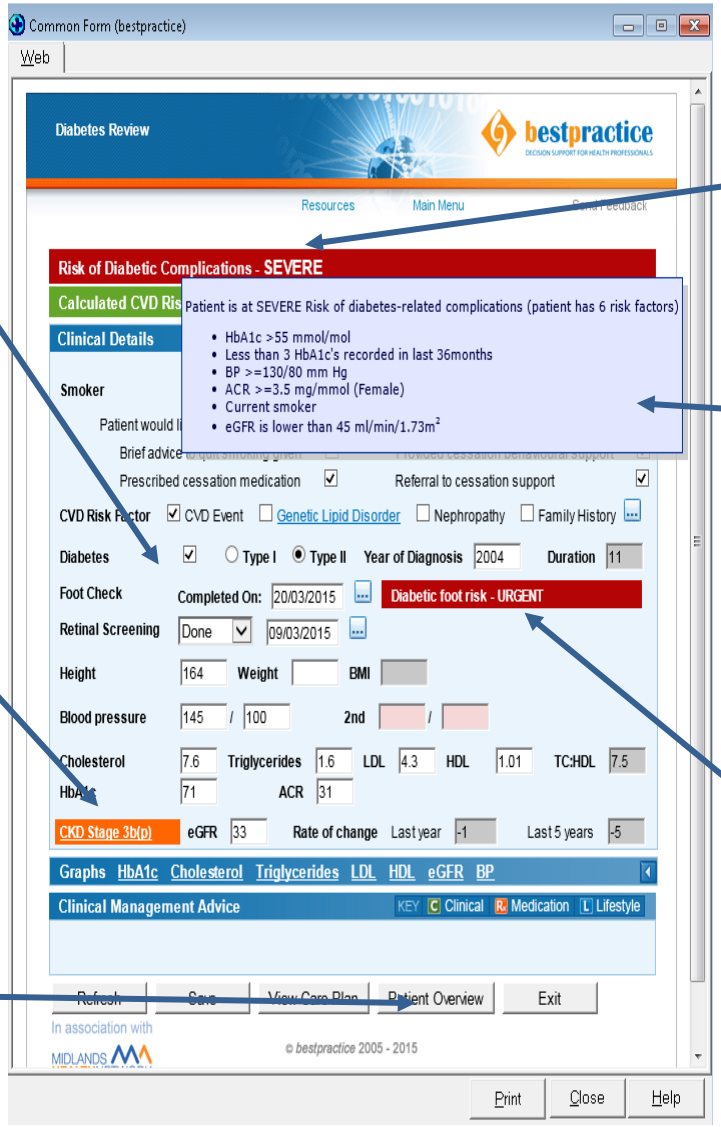
Standard set of laboratory investigations added. Others can be selected.

Diabetes/CVD: Clinical Module

Retinal screening results (images) can be uploaded and displayed. Improves patient understanding.

Patient is identified as having CKD stage 3b. Direct link to CKD module.

Click through to generate a personal care plan with patient specific objectives.



Risk of diabetic complications calculated and presented

Hover over any alert and the underlying parameters for the risk calculation are displayed.

Diabetic foot risk calculated. Click in to do assessment. Another click to initiate referral and one further click to complete and send.

CKD in consultation clinical decision module

NICE National Institute for Health and Care Excellence

Stage	Description	GFR (ml/min/1.73 m²)
1*	Kidney damage with normal or raised GFR	≥90
2*	Kidney damage with mild decrease in GFR	60-89
3A	Moderately lowered GFR	45-59
3B		30-44
4	Severely lowered GFR	15-29
5	Kidney failure (end-stage renal disease)	<15

Chronic kidney disease

early identification and management of chronic kidney disease in adults in primary and secondary care

Issued: July 2014 last modified: March 2015

NICE clinical guideline 182
guidance.nice.org.uk/cg182

NICE has accredited the process used by the Centre for Clinical Practice at NICE to produce guidelines. Accreditation is valid for 5 years from September 2009 and applies to guidelines produced since April 2007 using the processes described in NICE's 'The guidelines manual' (2007, updated 2009). More information on accreditation can be viewed at www.nice.org.uk/accreditation

NICE accredited

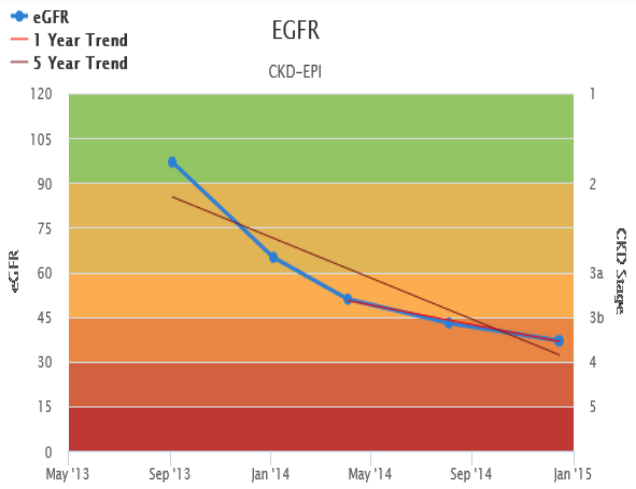
© NICE 2014

Extracts EGFR results from PRS (calculates EGFR from creatinine)

- Determines stage
- Does regression
- Determines estimated time to stage 4

Progressive CKD stage 3b

Charts

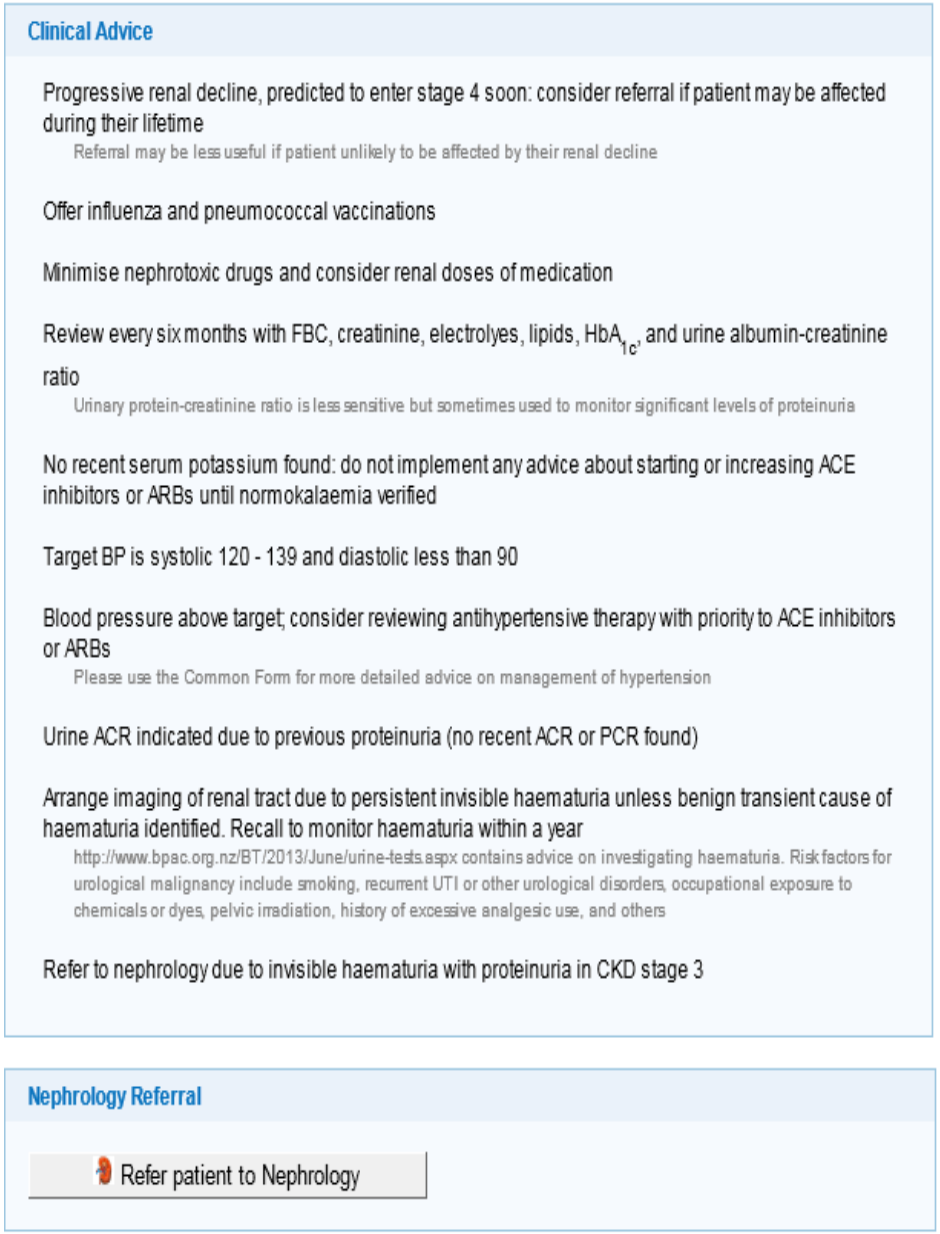


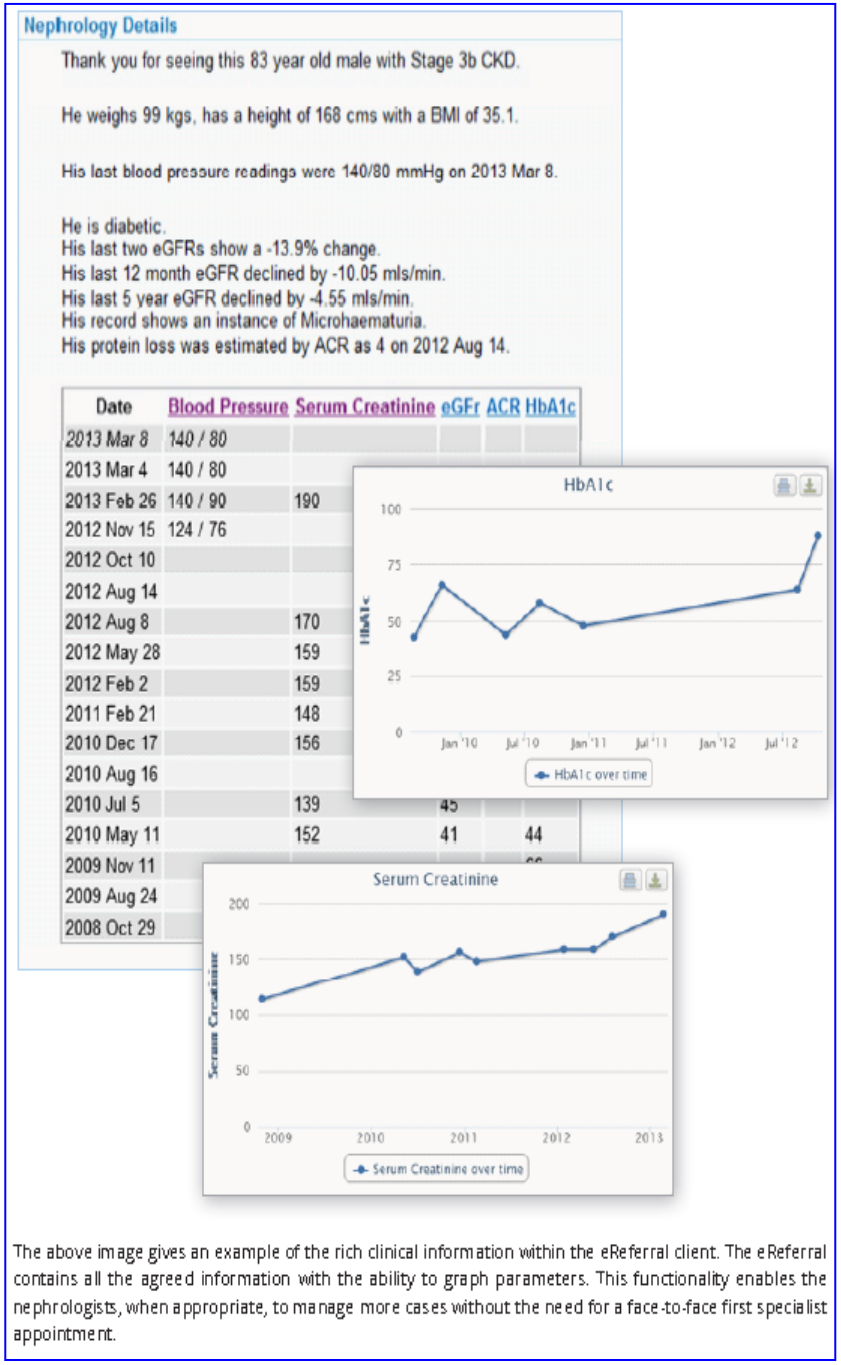
Current/Existing Data

Laboratory Results

Serum Creatinine (most recent)	175	µmol/l	(15/12/2014)
eGFR	37	ml/min/1.73m²	0% change from previous (15/12/2014)
Annual Rate of Change	-27	ml/min/1.73m²/year	(03/04/2014 - 15/12/2014)
Five Year Rate of Change	-208	ml/min/1.73m²/5 years	(03/09/2013 - 15/12/2014)
ACR (most recent)	45	mg/mmol	(01/09/2014)

Patient specific advice based on NICE Guidance

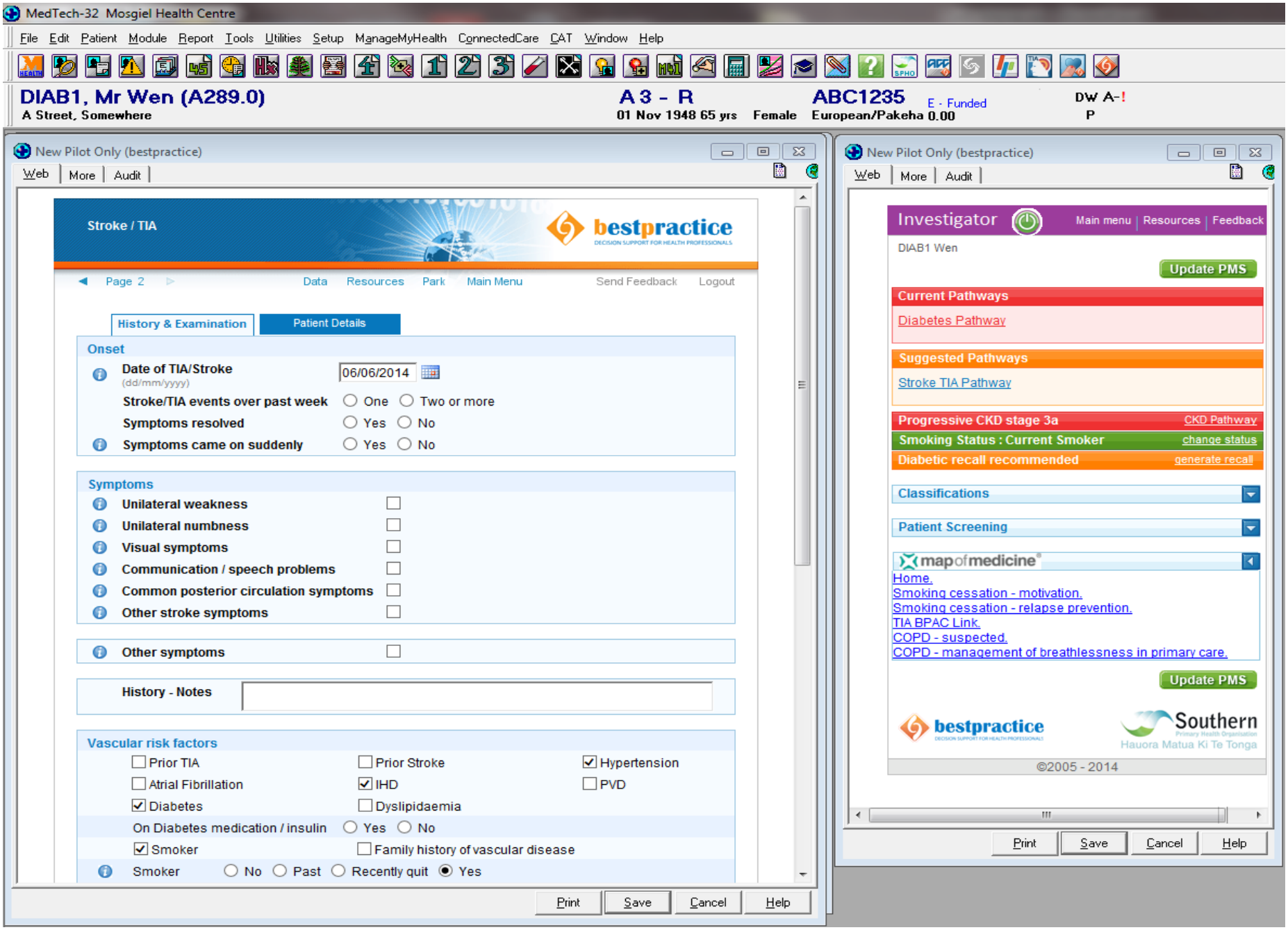


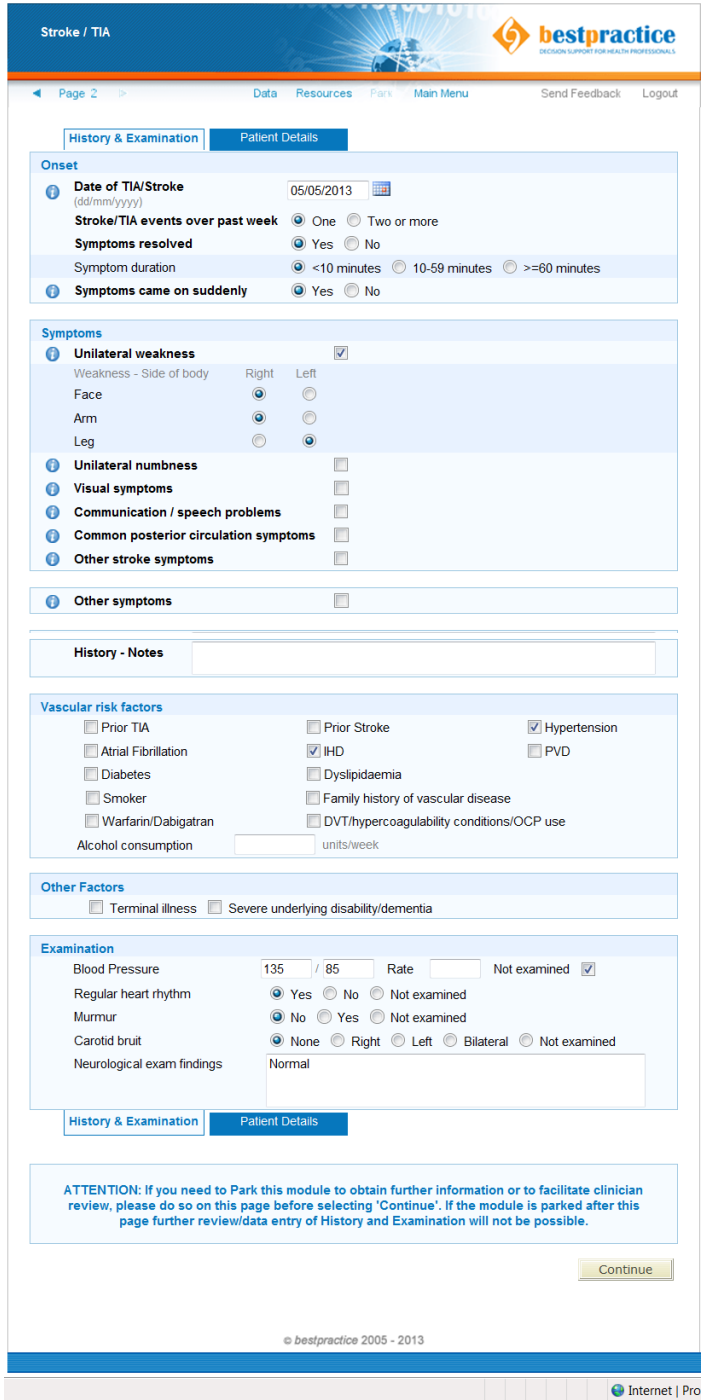


The above image gives an example of the rich clinical information within the eReferral client. The eReferral contains all the agreed information with the ability to graph parameters. This functionality enables the nephrologists, when appropriate, to manage more cases without the need for a face-to-face first specialist appointment.

bestpractice
DECISION SUPPORT FOR HEALTH PROFESSIONALS

Standardised electronic referral template


MedTech-32 Mosgiel Health Centre
File Edit Patient Module Report Tools Utilities Setup ManageMyHealth ConnectedCare CAT Window Help
DIAB1, Mr Wen (A289.0)
A Street, Somewhere
A 3 - R
01 Nov 1948 65 yrs
Female
ABC1235
E - Funded
European/Pakeha 0.00
DW A-!
P
New Pilot Only (bestpractice)
Web More Audit
Stroke / TIA
bestpractice
DECISION SUPPORT FOR HEALTH PROFESSIONALS
Page 2
Data Resources Park Main Menu Send Feedback Logout
History & Examination
Patient Details
Onset
Date of TIA/Stroke
(dd/mm/yyyy)
06/06/2014
Stroke/TIA events over past week
One
Two or more
Symptoms resolved
Yes
No
Symptoms came on suddenly
Yes
No
Symptoms
Unilateral weakness
Unilateral numbness
Visual symptoms
Communication / speech problems
Common posterior circulation symptoms
Other stroke symptoms
Other symptoms
History - Notes
Vascular risk factors
Prior TIA
Prior Stroke
Hypertension
Atrial Fibrillation
IHD
PVD
Diabetes
Dyslipidaemia
On Diabetes medication / insulin
Yes
No
Smoker
Family history of vascular disease
Smoker
No
Past
Recently quit
Yes
Print
Save
Cancel
Help
New Pilot Only (bestpractice)
Web More Audit
Investigator
Main menu
Resources
Feedback
DIAB1 Wen
Update PMS
Current Pathways
Diabetes Pathway
Suggested Pathways
Stroke TIA Pathway
Progressive CKD stage 3a
CKD Pathway
Smoking Status : Current Smoker
change status
Diabetic recall recommended
generate recall
Classifications
Patient Screening
mapofmedicine
Home.
Smoking cessation - motivation.
Smoking cessation - relapse prevention.
TIA BPAC Link.
COPD - suspected.
COPD - management of breathlessness in primary care.
Update PMS
bestpractice
DECISION SUPPORT FOR HEALTH PROFESSIONALS
Southern
Primary Health Organisation
Hauora Matua Ki Te Tonga
©2005 - 2014
Print
Save
Cancel
Help


Stroke / TIA
bestpractice
Page 2
Data
Resources
Park
Main Menu
Send Feedback
Logout
History & Examination
Patient Details
Onset
Date of TIA/Stroke
(dd/mm/yyyy)
05/05/2013
Stroke/TIA events over past week
One
Two or more
Symptoms resolved
Yes
No
Symptom duration
<10 minutes
10-59 minutes
>=60 minutes
Symptoms came on suddenly
Yes
No
Symptoms
Unilateral weakness
Weakness - Side of body
Right
Left
Face
Arm
Leg
Unilateral numbness
Visual symptoms
Communication / speech problems
Common posterior circulation symptoms
Other stroke symptoms
Other symptoms
History - Notes
Vascular risk factors
Prior TIA
Prior Stroke
Hypertension
Atrial Fibrillation
IHD
PVD
Diabetes
Dyslipidaemia
Smoker
Family history of vascular disease
Warfarin/Dabigatran
DVT/hypercoagulability conditions/OCP use
Alcohol consumption
units/week
Other Factors
Terminal illness
Severe underlying disability/dementia
Examination
Blood Pressure
135
/ 85
Rate
Not examined
Regular heart rhythm
Yes
No
Not examined
Murmur
No
Yes
Not examined
Carotid bruit
None
Right
Left
Bilateral
Not examined
Neurological exam findings
Normal
History & Examination
Patient Details
ATTENTION: If you need to Park this module to obtain further information or to facilitate clinician review, please do so on this page before selecting 'Continue'. If the module is parked after this page further review/data entry of History and Examination will not be possible.
Continue
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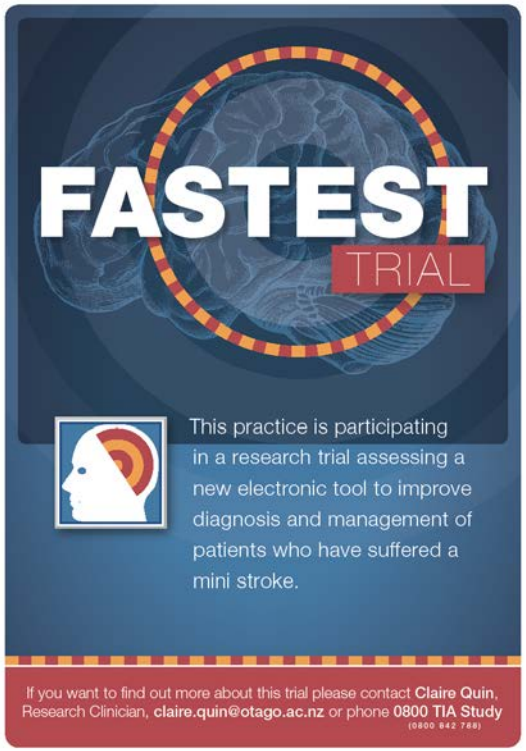
Internet | Pro

Stroke / TIA
Page 3
Data
Resources
Park
Main Menu
Triage
Management
Your patient may have suffered from a TIA and the estimated seven day stroke risk is Low
You have two management options:
a) Refer to TIA Clinic AND (before patient leaves surgery):
Initiate/continue ALL of the following Medications:
Clopidogrel OR Aspirin + / - Dipyridamole (UNLESS patient is on Warfarin or Dabigatran)
AND
Statin AND Antihypertensive
AND
Counsel patient on Smoking Cessation AND No Driving for minimum of 1 month.
Print TIA Information Leaflet
OR
b) Arrange comprehensive TIA/stroke work-up in the community (see 'Management' tab).
Triage
Management
ATTENTION: Please ensure that
handing them to the patient - this s
Land Transport Recommendations:
1. Private license (Class 1 and 2)
Single TIA: no driving for minimum of 1 month.
Multiple TIAs: no driving for minimum of 3 months provided the condition has been adequately investigated and treated.
2. Vocational license (Classes 2-5 and/or a P,V,I or O license endorsement)
Single TIA: no driving for a minimum of 6 months and then only if cause has been identified and satisfactorily treated, including a specialist assessment. Note that these individuals may resume private driving after a minimum of 1 month.
Multiple TIAs: people should not return to vocational driving. However the Director of Land Transport may consider granting a license 12 months after the last attack if an appropriate specialist report supports such an application.
TIA Risk Calculation (ABCD2)
Age: 1 pts (age >= 60)
Blood Pressure: 0 pts (bp < 140/90)
Clinical Features: 1 pts (Speech affected without weakness)
Diabetes on medication / Insulin: 0 pts (does not apply)
Symptom Duration: 0 pts (Duration of TIA < 10 min)
Your patient's ABCD2 score is: 2
TIA Risk Assessment
High Risk
ABCD2 score ≥4
≥2 events over 7 days
Atrial Fibrillation
Anticoagulation
Low Risk
ABCD2 score ≤3
≥7 days since last event
Based on ABCD2 score alone (excluding other high risk indicators) see table below for estimated stroke risk in %:
ABCD2 score 0-3 4-5 6-7
Proportion of all TIAs 34% 45% 21%
Stroke risk (%) at:
2 days 1.0 4.1 8.1
7 days 1.2 5.9 11.7
90 days 3.1 9.8 17.8
References

Efficacy and Safety of a TIA Electronic Support Tool (FASTEST): A cluster randomized controlled trial

Dr Anna Ranta, MD, FRACP
MidCentral Health and
University of Otago , New Zealand
ANZAN – Adelaide - May 2014



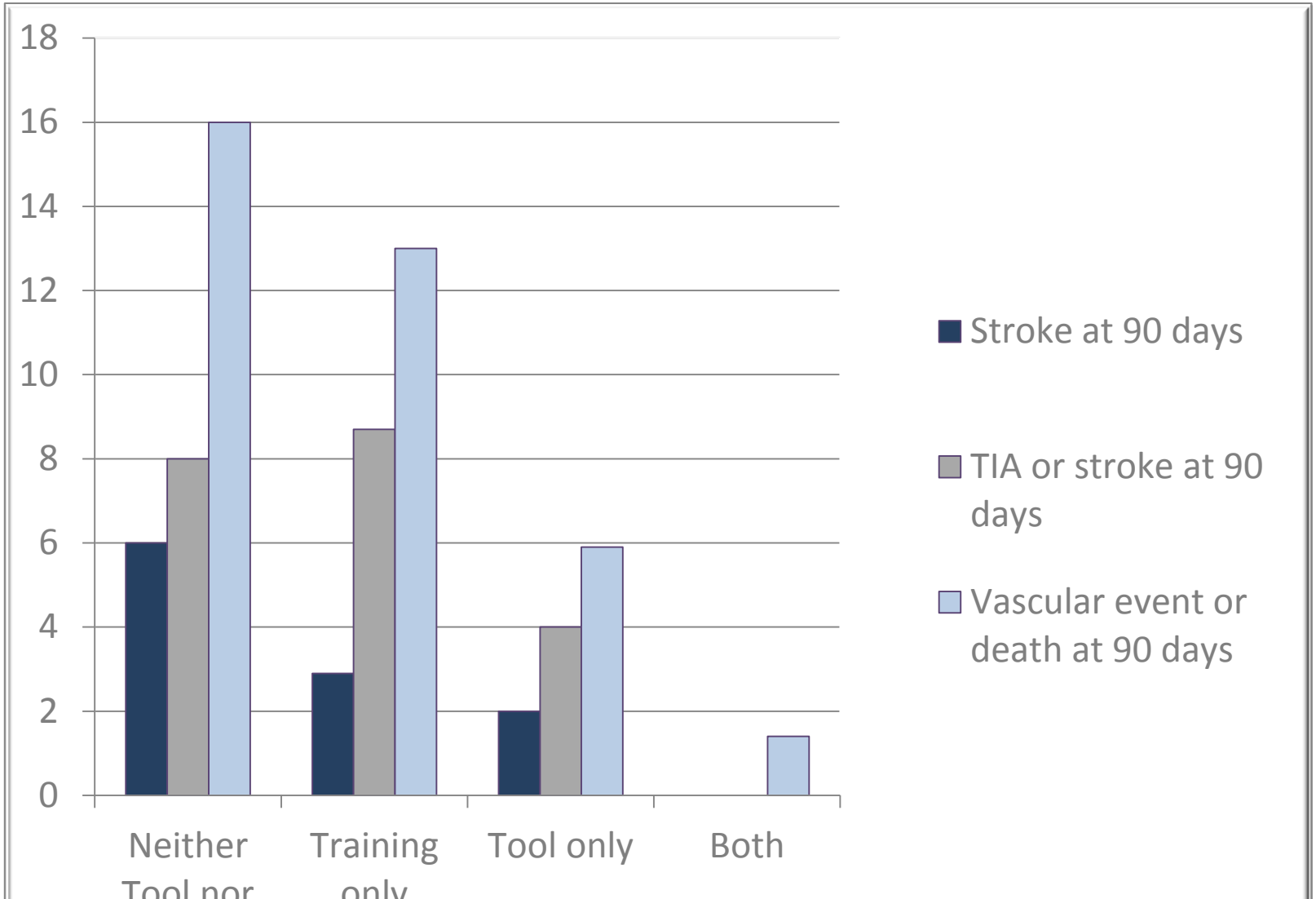
MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

University of Otago
Te Whare Wānanga o Otāgo

Efficacy Endpoints

Variable	Intervention (n=172)	Control (n=119)	Unadjusted for Cluster		Adjusted for Cluster	
	n (%)		Odds Ratio (95% CI)	P	Odds Ratio (95% CI)	P
Main end points						
Guideline adherence	131 (76.2)	49 (41.2)	4.56 (2.75-7.57)	<0.0001	4.57 (2.39-8.71)	<0.0001
Stroke at 90 days	2 (1.2)	5 (4.2)	0.27 (0.05-1.41)	0.098	n/a†	n/a†
Secondary end points						
TIA or stroke at 90 days	4 (2.0)	10 (8.5)	0.26 (0.56-0.85)	0.026	0.26 (0.70-0.97)	0.045
Vascular event* or death	6 (3.5)	14 (11.9)	0.27 (0.10-0.73)	0.006	0.27 (0.09-0.78)	0.016
Comprehensive counselling	68 (39.5)	19 (16.0)	3.44 (1.93-6.13)	<0.0001	3.44 (1.89-6.27)	0.0001

Outcomes


18
16
14
12
10
8
6
4
2
0
Neither Tool nor
Training only
Tool only
Both
Stroke at 90 days
TIA or stroke at 90 days
Vascular event or death at 90 days

Stratification - PEONY Model

Predicting Emergency Admission Over the Next Year
(Based on 1,409,506 general practice patients)

PEONY – Initially proposed from work in Tayside Scotland, Contains 34 variables from 2nd Care data & 1°Care Pharmaceutical use

Re-calculated the regression coefficients for each variable in New Zealand context

Using hospital and medicine use from 2008-2012 to predict patients with an acute admission in 2013.

Better than PARR (Patients at Risk of Re-hospitalisation) and the Combined Predictive Model (Kings' Fund)
PEONY - Not a ReAdmission Risk Score. It's an Admission Risk Score

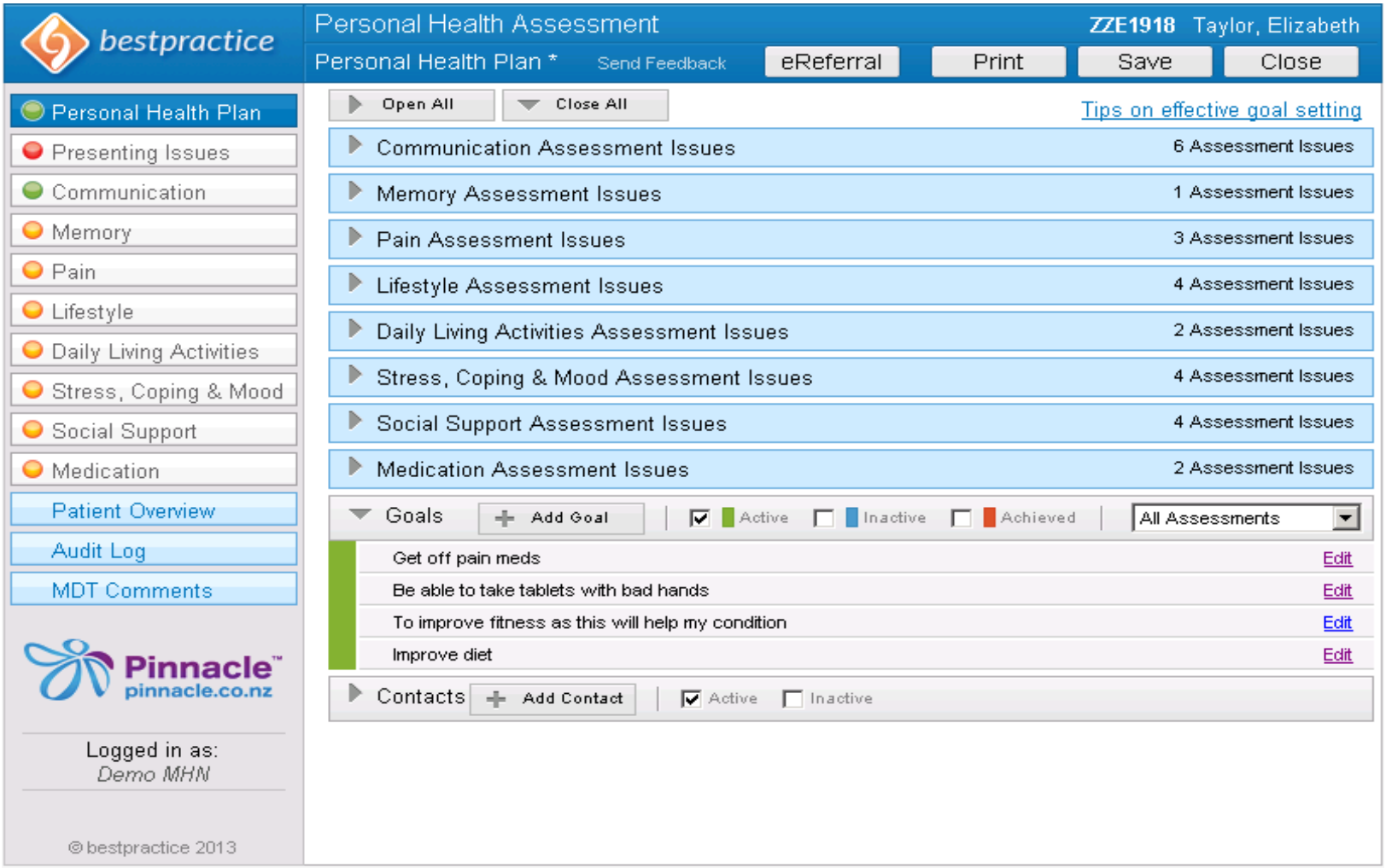
NZ PEONY - discriminatory power of 72%

New Zealand Risk Stratification

1,409,506 general practice patients were included

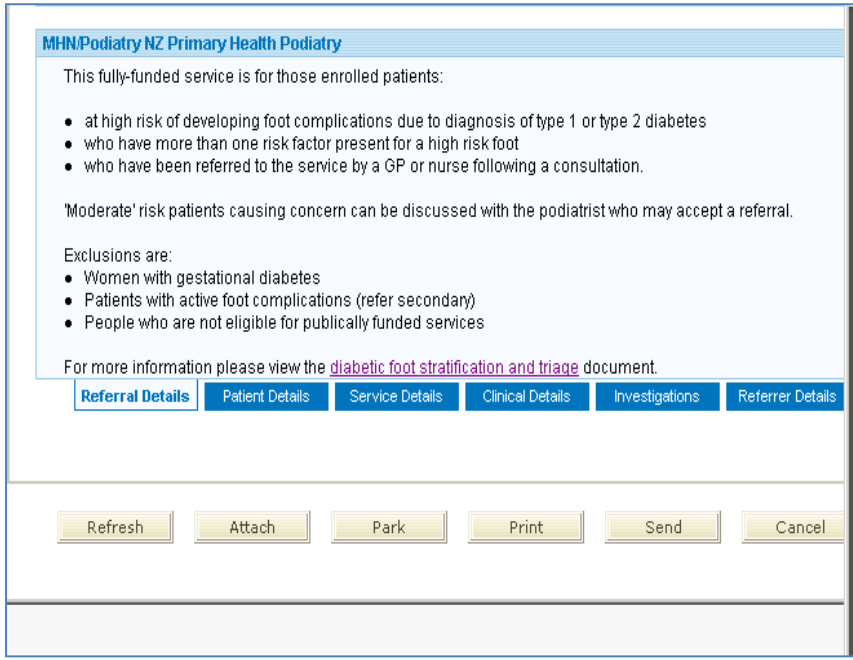
Probability of Acute Admission in 2013	Number of patients	2013 Acute Admission: Yes	No	Positive Predictive value
>=90%	597	419	178	70.2%
>=80%	1598	1126	472	70.5%
>=70%	3884	2589	1295	66.7%
>=60%	9173	5657	3516	61.7%
>=50%	20921	11564	9357	55.3%
>=40%	47,013	22,644	24,369	48.2%
>=30%	101988	40688	61300	39.9%
>=20%	222658	68355	154303	30.7%
>=10%	567005	111268	455737	19.6%
>=0%	1409506	154892	1254614	11.0%

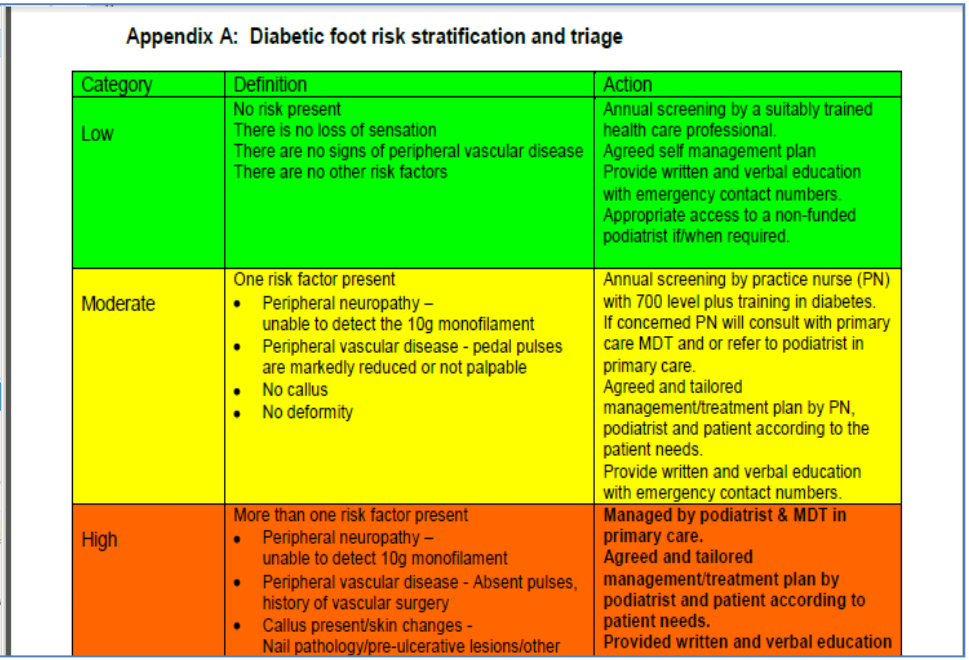
The Personal Health Plan creating, sharing & updating



The Personal Health Plan – eReferrals to MDT

- Dieticians to provide nutrition education for individuals and groups.
- Social workers to provide psycho-social support services.
- Pharmacists to optimise the patient's medicine self management and adherence
- Podiatrists to focus on the prevention and management of foot problems, a leading cause of hospitalization for people with diabetes



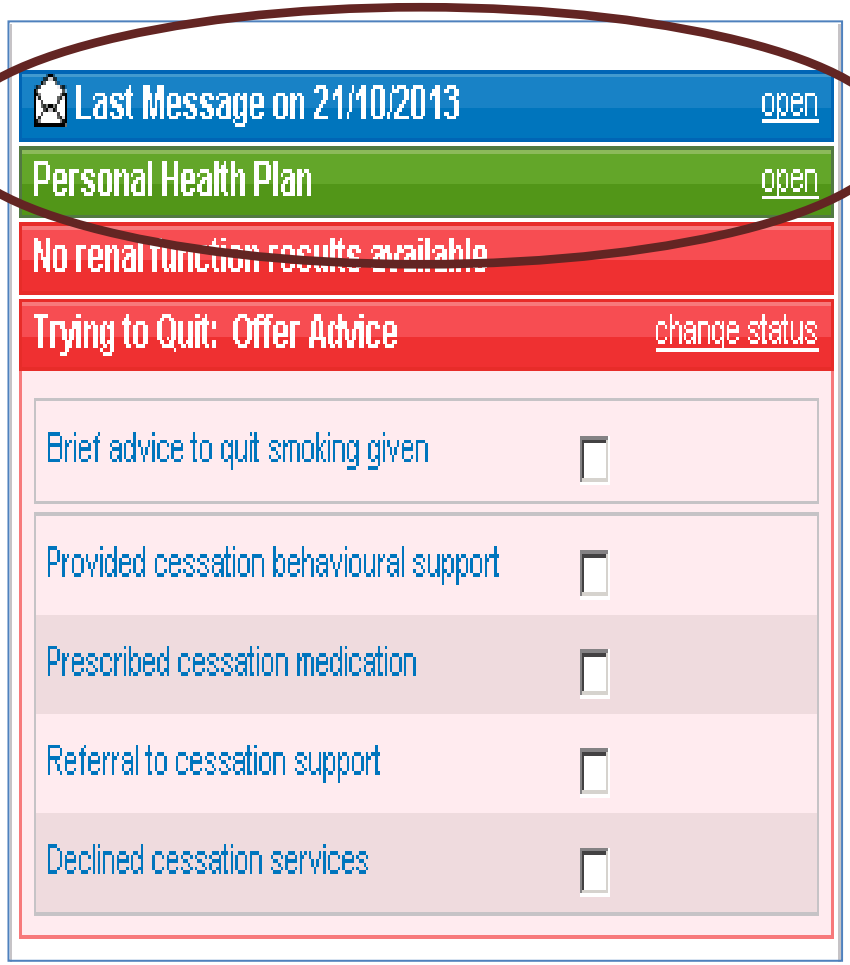


Appendix A: Diabetic foot risk stratification and triage

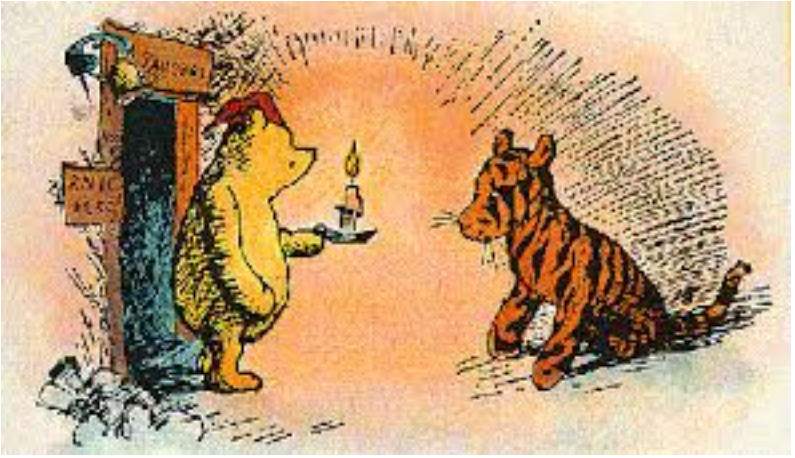
Category	Definition	Action
Low	No risk present There is no loss of sensation There are no signs of peripheral vascular disease There are no other risk factors	Annual screening by a suitably trained health care professional. Agreed self management plan Provide written and verbal education with emergency contact numbers. Appropriate access to a non-funded podiatrist if/when required.
Moderate	One risk factor present • Peripheral neuropathy – unable to detect the 10g monofilament • Peripheral vascular disease - pedal pulses are markedly reduced or not palpable • No callus • No deformity	Annual screening by practice nurse (PN) with 700 level plus training in diabetes. If concerned PN will consult with primary care MDT and or refer to podiatrist in primary care. Agreed and tailored management/treatment plan by PN, podiatrist and patient according to the patient needs. Provide written and verbal education with emergency contact numbers.
High	More than one risk factor present • Peripheral neuropathy – unable to detect 10g monofilament • Peripheral vascular disease - Absent pulses, history of vascular surgery • Callus present/skin changes - Nail pathology/pre-ulcerative lesions/other	**Managed by podiatrist & MDT in primary care.** **Agreed and tailored management/treatment plan by podiatrist and patient according to patient needs.** **Provided written and verbal education**

The Personal Health Plan – MDT replies visible in Patient Prompt

- **Accessing MDT replies from the Patient Prompt**
- Joined up working with integrated systems and messaging
- A banner on the Patient Prompt gives a ‘quick view’ of recent eReferral replies
- Open this, and you are taken to the eReferral Message Logging screen. You can select within this screen to view messages by patient, for your user account or by practice.



An increasingly joined up system



In conclusion

If the person you are talking to doesn't appear to be listening, be patient. It may simply be that he has a small piece of fluff in his ear.

Winnie the Pooh