Planned Proactive Care: *Care Closer to Home*

**How it Works**

1. Risk stratification and clinical judgement to identify individuals.

2. Special consultation to create patient-centred care plan. Plan holds identified goals and time milestones.

3. Shared plan activates coordinated suite of clinical and social support.

4. MDT case conferences held if needed. Plan is reviewed, updated and altered.

5. Review after one year and patient graduated from programme or re-enrolled. Early exit if mutual decision not to continue.

**Programme in Conjunction with Counties Manukau Health**

- **Total Patients:** 29,213
- **ProCare Patients:** 12,487

*As at 30 June 2021*

**Benefits**

- Patient-centred care planning
- Care coordinator assigned to each patient
- Flexible funding to allow individualised packages of care
- Multi-disciplinary teams
- Shared technology system
- Change management
- Business modelling
- Improved access to specialist care

**Improved Diabetes Management (Early Outcomes – HbA1c)**

- **HbA1c (mmol/mol):**
  - Months since enrolment: 58, 64, 70, 76
  - Enrolment date

**Diagram Elements:**

- GP
- Practice Nurse
- Pharmacist
- Social Worker
- SMO
- Psychologist
- District Nurse
- Other A/H