Bridging the Integrated Care Journey

THE ENGAGE SUITE
FOR CARE COORDINATION

AGFA HealthCare

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It seems paradoxical. On the one hand, your patients actually spend most of their time outside of the hospital, whether they are recovering, or receiving revalidation, palliative or mental care, etc. On the other hand, the vast majority of patient information is generated within a healthcare facility: everything from images, to lab results, to reports, etc.

A care model that minimizes time spent in the hospital is attractive for the patient's experience, and the overall economic impact.

But multimorbidity and long-term or chronic illnesses are not one-off care events. These are health situations that require a complex matrix of care, inside and outside the hospital, over time, by multiple stakeholders.

Each stakeholder needs specific information on the patient, and each can provide unique insights. We need to bridge the gap between home and hospital, between caregiver and care coordinator, between today and tomorrow, … Or, in a few words, we need to enable 'connectivity, alignment and collaboration'[1].

A complex matrix of stakeholders

Integrated care must engage with:

- Patient and caregivers
- Care coordinators, case managers, care directors, etc.
- Care professionals within the hospital/ hospital network: from all specialties involved in the patient's care
- Care professionals outside the hospital: GPs, external specialists, homecare nurses, home aides, social workers, etc.

1. See, http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf

The Engage Suite modules provide all three:
connecting sites and stakeholders, enabling multi-directional sharing and communication, and empowering coordination.

Each player can provide and access patient information from his own horizon, so that each becomes a full collaborator in facilitating the patient's care.

Patient engagement becomes the heart of the care continuum, with self-care support that helps the patient to manage his health at home, and follow the care plan.

What can the Engage Suite do for you and your patients?

Support the creation of clear care plans that so that all stakeholders know their responsibilities and tasks.

Create a single, consolidated patient view that every authorized person can access.

Enable direct communication between all of the patient's care providers.

Allow health indicators, vital signs, photos, etc. to be taken and uploaded from home (including via wearable devices and various apps).

Provide continuity between care teams, facilities and home care.

Enhance collaboration between all players in the patient's care continuum.

Empower all care providers to share information to make informed decisions.

Help reduce unnecessary visits to the hospital or care provider.

Enhance patient engagement and satisfaction.

Engage Suite Patient Journey

Use Case:

A united care team for elderly patients

Frail elderly patients often are subject to multiple care regimes, take multiple medications and have a large circle of medical and non-medical caregivers. They are also at high risk of re-hospitalization, so coordination between all stakeholders is important.

In addition, caregivers within the home often do not have access to devices for recording information digitally: paper notes are still the norm in many cases. And with so many different specialists involved, specific caregivers may not be aware of evolutions in the patient's situation.

A regional innovation project in France aimed to bridge the gap between hospital and primary care, and to 'decompartmentalize' the relationships between players inside and outside the hospital, and between different types of caregivers.

Using a social media network format, it enables everyone in the patient's circle of care to communicate with one another.

Patient data – weight, blood pressure, glucose, etc. – can be directly uploaded via connected devices or can be entered manually. Alerts are automatically sent to all stakeholders via notification.

- Everyone in the care continuum can add and access patient health data.
- Care coordination and continuity are strengthened.
- Home nurses can directly add their notes to the electronic patient record.
- Redundancy in information collection is reduced, saving time, effort and resources.

Step by step along the journey

1. Align and connect

When a patient with multimorbidity or chronic illness leaves the hospital or doctor's office, it isn't the end of care, but it is the start of a new phase of care. You can accompany the patient every step of the way, with direct, two-way communication between all caregivers, including home nurses, GPs, social workers, physical therapists, etc.

Healthcare providers can effectively create and manage care plans for patients, and coordinate care teams. All care professionals know what they need to do and can reach out to each other for collaboration, using a range of tools that support coordination and communication with colleagues.

The Engage Suite offers an overview of the patient's medical data: reports, documents, images, results, and more. All stakeholders are thus viewing, sharing and collaborating based on the same information, but can easily search and organize the information relevant to them.

- Support continuity along the patient's care path.
- Help care teams to create, develop and follow up care plans.
- Provide access to data from different sources.
- Store or visualize information in the EMR to eliminate parallel systems that must be monitored.

2. Monitor

Indicators and vital signs – whether for heart disease, pulmonary disease, diabetes, obesity, etc. – can be checked at home and then uploaded via mobile devices, saving the patient an unnecessary trip to the doctor.

Images, such as pictures of wounds or stoma, can be shared with the care team for feedback and instructions. This information is integrated into the Engage Suite, where it is stored in a secure way. If certain indicators in the overview or results raise a concern, the care team can take action.

- Improve the follow-up of your patients at home.
- For chronic conditions that require more permanent monitoring, the care team is connected.
- Patient and care team can be reassured that treatment is progressing as expected.

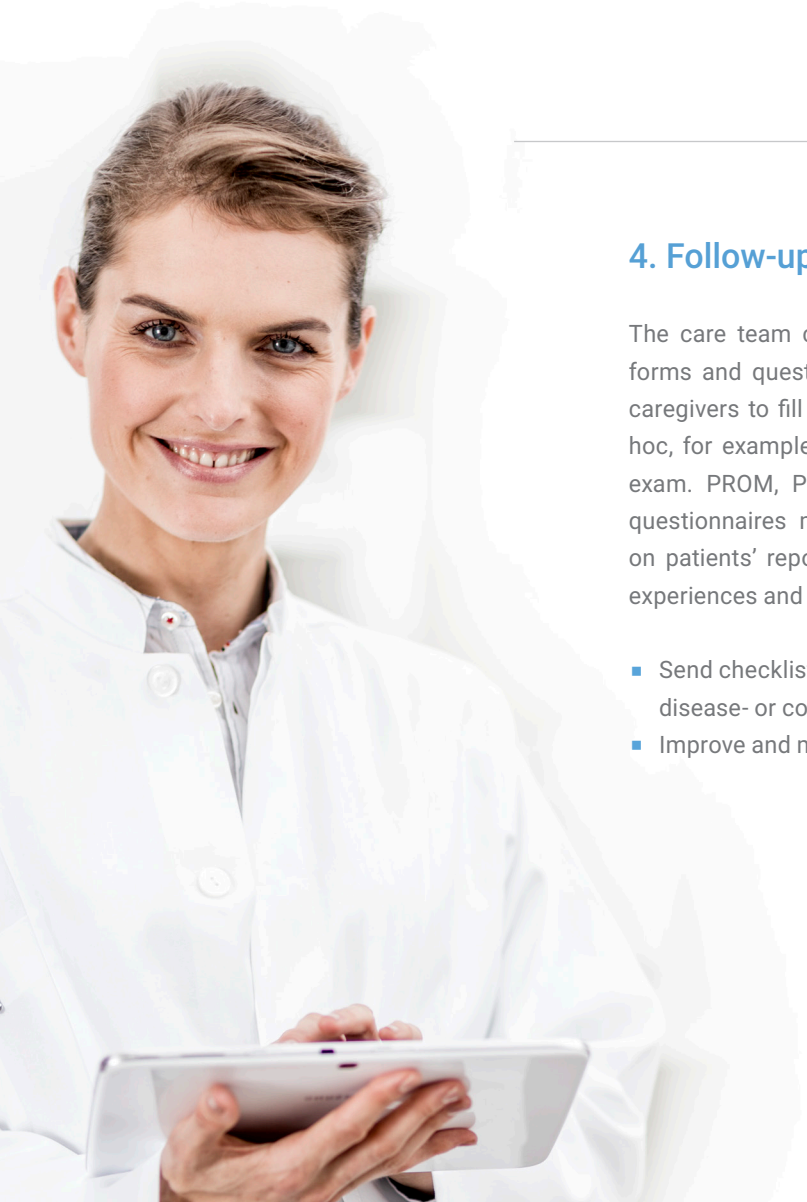
3. Collaborate & video conference

Information from all stakeholders is included in the central patient record: the care team can closely monitor the evolution of the patient's therapy and condition, and all stakeholders become full collaborators in the patient's ongoing care.

Over video conferencing, the care teams can discuss results, treatment and follow-up, while having access to information they need. This not only includes reports, medical documents, lab results and images, but also notes and other information from the home-based caregivers.

They can share any changes to the care plan with their colleagues, who can then verify the patient is following the treatment to achieve the desired outcome.

- Facilitate a multidisciplinary approach to enable optimal outcomes and reduce readmissions.
- Enable video conferencing, care coordination and continuity of care.



4. Follow-up

The care team can also provide or create forms and questionnaires for patients and caregivers to fill in, whether regularly or ad hoc, for example before or after a specific exam. PROM, PREM and disease-specific questionnaires make it possible to check on patients' reported outcomes, wellbeing, experiences and quality of life.

- Send checklists, PROM, PREM and other, disease- or condition-specific questionnaires.
- Improve and measure patient satisfaction.

5. Engage

Support and increase your patients' engagement in their own care and therapy. They can download their health data, or share it with others via a link. They can see an overview of their medical and clinical information, such as weekly results and scores. They can upload additional health data, or take pictures and send them to the care team for feedback and instructions.

The care team can also send instructions to the patient and caregivers. By providing patients with standard information and FAQs, you can free your staff from answering routine, repetitive questions and enable them to concentrate on value-added tasks that require their expertise.

For example, new physiotherapy exercises can be updated regularly or when specified milestones are met. Video instructions for refilling or recharging implants, pumps or other equipment can be included.

Patients feel confident that they are being well followed-up, while the care team can check on their status and satisfaction.

- Enable patients to actively participate in their own care and progress.
- Provide patients with "anywhere/anytime" access to their health data.
- Increase patient satisfaction and experiences.

6. Plan

When visits, consultations, examinations, surgical and other interventions need to be scheduled at the hospital, the patient or caregiver can use the planning tool via an easy-to-use interface.

Patients can check and modify appointments on line, helping to ensure that they don't miss a consultation, exam or intervention.

- Enable 24/7 online scheduling and modification, including via mobile devices.
- Enhance the patient experience and satisfaction.
- Provide secure access to online services.

Contact your local Agfa HealthCare representative for a demo

www.agfahealthcare.com

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