HealthShare Care Community

Managing care in distributed healthcare systems

In England the NHS reports 30% of the population, and globally one in three adults, live with long-term conditions that require continual health monitoring, with a further 5% of those with multiple conditions requiring specialist interventions. Remaining healthy and well in their homes is a top priority.

HealthShare Care Community is a solution that enables care teams to create a comprehensive care plan with the benefit of real-time access to the HealthShare unified care record - improving communication, care transitions, and care coordination outside of the hospital setting.

Patient Journey with Care Community

Marla is in her eighties and wants to remain mobile and live independently.

Patients such as Marla equate to 50% of GP appointment & 70% of NHS appointments.[1]

During a visit to her GP, a Care Plan is created to help meet her personal healthcare goals.

NHS plans to roll out personalised care to reach 2.5 million people by 2023/24.

Marla subsequently suffers a fall at home and is admitted to her local Emergency Department.

90.2% of hospitals in the UK regularly exceed 95% capacity.[2]

The Emergency Department physician accesses Marla's care record and can see her Care Plan with complete medical history and care team.

Doctors treat Marla and add a physiotherapist to her care team. Together, they create a care plan for Marla so she can continue living independently.

Marla is discharged from the Emergency Department.

Upon discharge, an event notification is delivered to all her care givers regarding the update to her care plan.

Marla undertakes regular visits with her primary and community care team, and now also her physiotherapist.

Each care provider updates the plan during visits with all other team members able to check Marla has been attending her scheduled appointments.

Marla completes her subsequent treatment with her care team to improve her mobility and avoid future falls.

Personalised Care Plans combine input from the care team with additional lifestyle and wellness goals important to the patient.

Using HealthShare Care Community, everyone on the team can see who is contributing to the patient's care; when they're involved; what role they serve; and their contact information.

Teams can be notified automatically upon patient-related events such as admissions, discharges, or transfers. Through the HealthShare clinical message center, person to person communication among team members is saved for future reference.

HealthShare Care Community provides a library of discrete data elements which can be exported into the Unified Care Records data model and accessed for reporting.

With HealthShare Health Insight or other analytics tools, you can identify patients in high- and rising-risk populations and customise care plans accordingly.

Powered by HealthShare Unified Care Record enabling patient information and care plans to be shared with other healthcare and care providers using a variety of interoperability standards, including HL7 FHIR® - giving full visibility of the patient and the care team involved.

With HealthShare Care Community, care givers and patients can work collaboratively to support long-term wellness and patient needs.

TAKE THE NEXT STEP

To learn more about HealthShare Care Community, go to InterSytems.com/care-community

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1. Patients such as Marla equate to 50% of GP appointment & 70% of NHS appointments – RCGP. 2. 90.2% of hospitals in the UK regularly exceed 95% capacity – Kings Fund.