Fonofale, House of Care, Wagner Model, Managed Care, Reducing inequalities...
Outline

• Big Picture

• Population and primary care approach

• Factors affecting people

• Diabetes and CVD

• Multimorbidity

• Self Management

• Structured care

• Practice effectiveness
Vision:

New Zealanders living with Long Term Conditions can expect:

- High quality, patient focussed care
- That is integrated across the health system
- And to be regarded as leading partners in their care
WHO target (May 2013): “To reduce premature deaths from NCDs by 25 per cent by 2025”
Deaths per 100,000 population

Source: Adapted from E. Nolte and M. McKee, “Variations in Amenable Mortality – Trends in 16 high-income nations” Health Policy, Sept 2011
Long Term Conditions in New Zealand

• Prevalence is rising
• 60% more over 65 year olds by 2026
• Most will have good health
• But one in five will have a mental disorder
• And multiple conditions are common
• NCDs cause 80% of all NZ deaths
Wellbeing

“While people with good health tend to have high wellbeing this is not always the case- 38% of people with poor health have high wellbeing and 18% of people with good health have low wellbeing”


--2013 in “Wellbeing why it Matters to Policy” DOH.
Population need

- Level 3: High complexity
- Level 2: High risk
- Level 1: 70-80% of CDM population

- Case management
- Disease management
- Professional care
- Self care support/management
Making Management Easier

Three aims:

- Improve Health of population
- Improve patient experience and outcomes
- Reduce and control costs

“Co-morbidity is common so person focused assessments are more important than disease focus”. (Starfield)
Patient Centred Care

"Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”

IOM (Institute of Medicine)
Primary Care

The benefits of primary care (person-focused, comprehensive, and coordinated) are greatest for people with high morbidity burdens.

The focus on disease management has not proven useful in improving health due in part to lack of integration with primary care and a whole of person approach.

Even the chronic care model will not be useful unless it is carried out in the context of good primary care.

Integrated Care

“The Management and delivery of health services so that clients receive a continuum of preventive and curative services according to their health needs over time and across different levels of the health system”

WHO 2008
Moving towards whole of system integration:

- Challenge is to identify and effectively provide service within the primary care model of continuity over time (nurses navigators)

- Primary Care teams expert already in generalist approach but restructuring variable towards LTC approach

- Specialist care “pit stop” patient, population and educational support
Coordinated Care for people with long term conditions (Kings Fund 2013)

Highlighting:

• Holistic focus, self-management, focused on functional independance and wellbeing
• Continuity
• Carers important
• Link with communities
• GP involvement
• Good links with secondary care / also single point of entry
• “High touch low tech”
PATIENT EXPERIENCE:

- Patient centred
- Shared decision making
- Self management support
- Use of technology
Self management and shared care pilot in General Practice

The provision of an innovative patient-centred model of care for people with Long Term Conditions (LTCs) in general practice.

• Pilot model to be delivered by one provider at two demonstration sites, one rural and one urban

• Strives to empower people with LTCs to successfully self-manage their condition using a collaborative process of shared decision making to agree goals, identify support needs, develop and implement action plans and monitor progress

• Aims make the best use of available secondary services and allied health professionals to form a whole system approach to managing LTCs.
RESTRICTURING HEALTHCARE

• Need for sustainability
• Overall systems change required
• Can build on what is in place
Having up to date disease coding for your enrolled population is essential for active management.

- **Identify those who might need proactive check ups.**
- **Due to co-morbidities, actively managing one condition can help prevent or control others.**  
  *Eg dementia less than predicted in UK*
- **Safety**
WORKFORCE / LEADERSHIP

• Identified leader/champion within the practice (often nurse led)

• Team culture & team approach in practice

• Training and development supported and encouraged by PHO and practice

• PHO provides direct support and facilitation
ACCESS

• Funding and/or clinical models used to offer structured care

• Wrap round services provided by PHO

• Phone/texting systems support recall and management

• Links with local communities and workplaces
Diabetes population management approach

- **Identification:** More Heart and diabetes checks
- **Management:** DCIP development
- **Prevention:** Green Prescriptions
LIFESTYLE CHANGE IS DIFFICULT
Managing pre-diabetes

Losing 5-10% of overall body weight reduces risk by 50%
Managing Pre-diabetes

1. *Provide lifestyle advice*
2. *Link with community support & activities (GRx)*
3. *Address other contributing issues (depression, nutrition etc)*
4. *Agree a schedule of follow up intervals*
5. *Metformin?*
Pre diabetes pilot

The Diabetes Team is working to contract three pre diabetes pilots. They will:

• Target the population group/s most at risk of developing type 2 diabetes in their area.

• develop at least three additional clinics in outlying areas

• work with Dieticians to conduct monthly nutritional workshop

• work with Dieticians to facilitate monthly healthy cooking demonstrations

• track repeat measures for weight, BMI, girth, blood pressure at six months and six months post discharge

• obtain repeat HbA1c measures at six months and six months post discharge

• Lessons learnt from these pilots will be shared with the sector as part of the toolkit to support the implementation of the Standard around prediabetes
Health Target Progress – 73% Q2 2013/2014

More heart and diabetes checks Q1 and 2 2013/14 results

newzealand.govt.nz
CVDRA guideline updates

The majority of patients with:

an estimated 5 year combined CVD risk below about 10% will generally be able to be well managed without drug treatment

an estimated 5 year combined CVD risk between about 10-20%, will benefit from a shared discussion about the benefits and harms of blood pressure and lipid lowering drugs

a combined CVD risk over about 20% including patients with a personal history of CVD, are likely to benefit significantly from both blood pressure, lipid-lowering and anti-platelet medication, over and above intensive non-pharmacological interventions.
Predicted benefits of increasing LDL-C reductions with statins by baseline absolute CVD risk: vascular events avoided per 1000 treated for 5 yrs
CVDRA guideline updates – Lipids

For combined risk over 20%, monitoring of non-fasting lipids every 3 to 6 months until stable and then every 1 to 2 years is recommended.

For combined risk under 20% a moderate reduction in LDL-C is the aim and re-measurement could wait until the next combined risk assessment.

Following lifestyle management interventions non-fasting lipids should be repeated at time of review, usually 6 to 12 months.
Tobacco Update

• 135,000 fewer smokers now (census data)

• 23% reduction from 2006-2013 - now 465,000

• Currently 15% adult population smoke

• That means 154 smokers/GP
Diabetes care areas

Diabetes affects every area of life and every area of healthcare

- Prevention and risk management
- Diagnosis and ongoing care
- Complications from diabetes
- Lifestyle management
- Retinal screening
- Cardiovascular care
- Palliative care
- Pregnancy
- Neuropathy care
- Inpatient and emergency
- Renal services
- Podiatry
- Services for older people
- Children and youth
- Learning difficulties / mental health

People with diabetes
Diabetes – what we know

AMPUTATIONS
(2006-2012)
Total number up 29%
Diabetes population up 63%

Overall rate of amputations for people with diabetes down 15%
Diabetes – what we know

HEART EVENTS
(2006-2012)

Total number up 17%
Diabetes population up 63%

Overall rate of heart events for people with diabetes down 44%
Improvement - Deaths from diabetes

Deaths attributed to Diabetes

source: MOH Mortality reports
Proposed initial system measures

**Improved health and equity for all populations**
- **Healthy Start (conception to 1 year)**
  - Enrolled in a PHO within three months;
  - Birthweight in healthy range;
  - Smoking status recorded and ABC offered to mum;
  - Increased immunisation;
  - Enrolment with an LMC within ten weeks

**Best value for public health system resources**
- Standardised number of acute inpatient bed days per capita
- Reduced variation in tests, prescriptions and referrals

**Improved quality, safety and experience of care**
- **Safety**
  - Hospital admission due to falls
  - Age 65+ 5,6,7 long term medicines;
  - Age 65+ 8,9,10 long term medicines
  - Age 65+ 11+ long term medicines
  - Hospital admission due to medication errors

**Healthy Child**
- Increased immunisation
- B4 School Checks coverage

**Healthy Adult**
- Better help for smokers to quit
- More heart and diabetes checks: diabetes and CVD risk assessments
- Cervical screening coverage
- Breast screening coverage

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**Capability and capacity: Enabling leadership**
- Shift in investment - % spend between primary/community vs. secondary care
- Proactive service configuration – patient time saved on end to end pathway
- Proactive general practice teams - might include 70% GP VR, PHO education, evidence based care and support for general practice teams, continuous quality improvement
- Enabling infrastructure including various key items of IT capacity, including shared care records
- Measurement of resource utilisation
- Effective alliance participation
- Number of IFHCs being supported in development by MOH or DHBs
- Expanding role of pharmacists, e.g. immunisation, warfarin, prescribing, use of Medicines Therapy Assessment Pharmacists.

**Capability and capacity: Enabling access**
- Shorter stays in ED
- Patient touch by setting, e.g. general practice surgery face to face, general practice text, hospital, outpatient clinics
- Programme for managing variation in tests, prescriptions and referrals
- Outpatient DNA rates – Total
- Secondary health service utilisation un-enrolled in a PHO
Q&A

From a clinical perspective:

Audience - How is LTC management working for you?

• What does effective integrated healthcare look like for you in your area?

• How does self –management & goal setting with patients work in your practice?

• Do you have the tools/resources (people/systems) required to carry out effective goal setting for people with LTC?

• Which one factor would help increase effectiveness for you?

• Do you share success/results with the clinical community?
Potential future development of system measures

**Improved health and equity for all populations**
- Healthy child
  - Live in smoke-free home
  - Child poverty
  - Child safety, eg. accidental injury
  - Obesity
- Healthy adolescent
  - Sexual health
  - Mental health
  - Lifestyle measures
- Healthy adult
  - Obesity/BMI
  - Unable to work because of ill health
- Healthy Ageing
  - Long term condition management, eg. acute presentations for asthma, COPD heart failure out of hours

**Best value for public health system resources**
- ED acuity rates, conversion rates
- Polytesting use of laboratory tests
- Capacity to manage referred service variation

**Improved quality, safety and experience of care**
- Patient experience, including access
  - HQSC patient experience measures
Diagram 1: Structure of the proposed framework

**Triple Aim Dimensions**

- **Breakthrough**
  - Improved quality, safety and experience of care
  - Improved health and equity for all populations
  - Best value for public health system resources
  - Measures not predetermined
  - Measures apply equally to Practices, PHOs and DHBs, reflecting the goals of programme innovation

- **Excellence (Higher thresholds)**
  - System level measures in common across practices, PHOs, DHBs
  - Contributory measures, for each of practices, PHOs, DHBs

- **Improvement**
  - System level measures in common across practices, PHOs, DHBs
  - Contributory measures, for each of practices, PHOs, DHBs

- **Entry**
  - DHB Accountability Framework
  - Quality Accounts
  - PHO Minimum Requirements
  - RNZCGP Foundation Standards

**Incentives**

- **Maximum freedom to innovate, flexible accountability framework**
- **Financial Reputational**
  - Increased influence
  - Increased ability to lead innovation
- **Sanction**
Reduction in tobacco sales since 2009:
364,382 Kg less tobacco sold
= 300 million fewer cigarettes per year
Discussion – What do you need to manage LTC more effectively in your practice/area?

- Accurate coding that identifies all long term conditions and other relevant clinical information
- Information available at the time of patient contact to support best practice care
- Appropriate decision support for identification and management
- Relevant recalls in place
- Audit and feedback to support best practice
- An established structure for managing Long Term Conditions
- An ability to use the information for population health
- An ability to intensify management for people at risk of complications.
- Specialist nurse support
- Support from secondary care for advice and clinical review
- A system for sharing care for higher risk people
- An ability to support patient self management and effective communication with patients, for example use of a patient portal.
- A PHO that can provide support, including wider comparative data