Dr Helen Rodenburg

General Practitioner

Wellington

Making Chronic Disease Management Better - Concurrent Workshop Repeated

Saturday, 17 August 2013	Start 2:00pm	Duration: 55mins	Monet
	Start 3:05pm	Duration: 55mins	Monet

Making long Term Condition Management easier

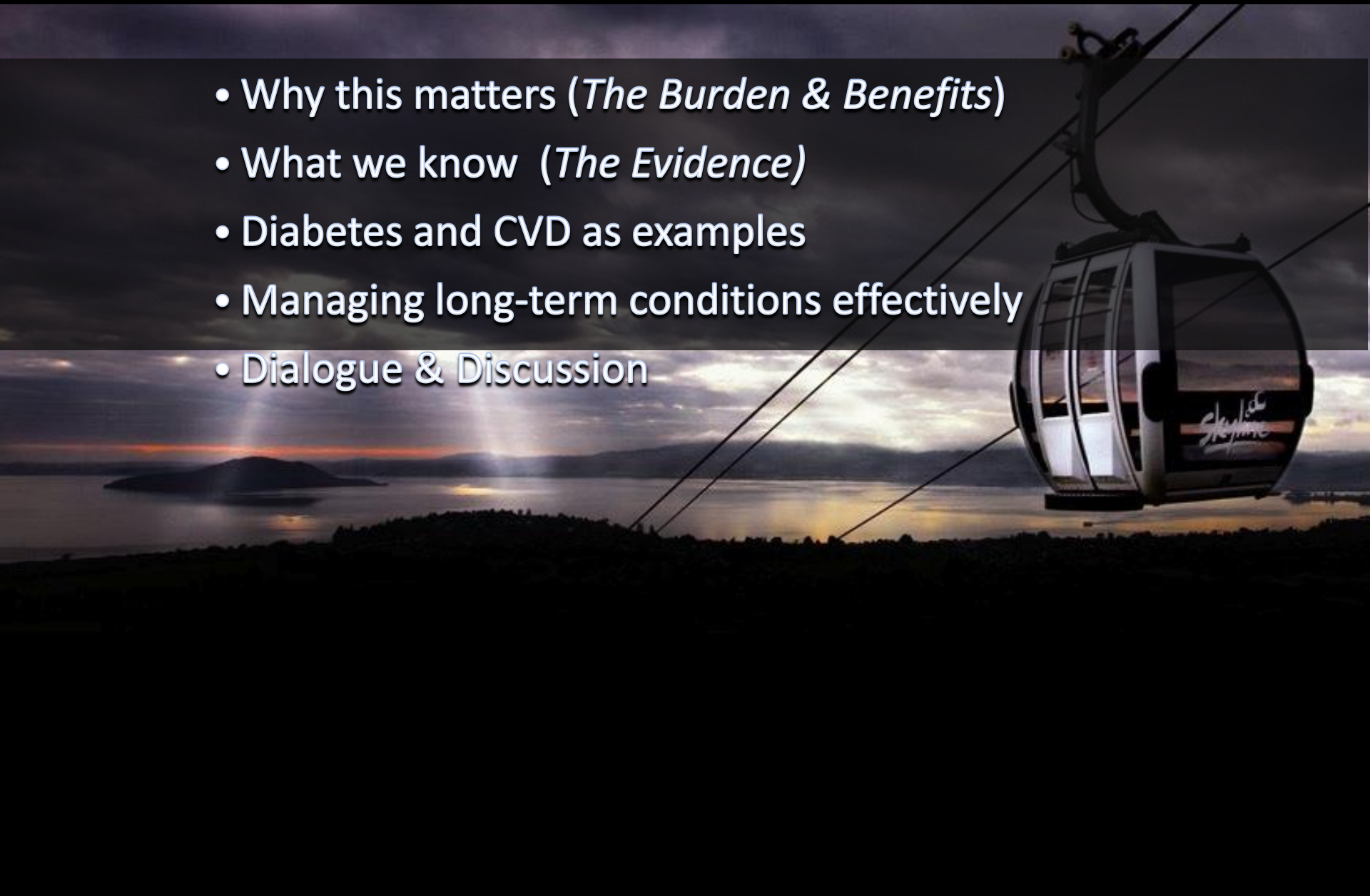
CVD and diabetes as examples

Helen Rodenburg

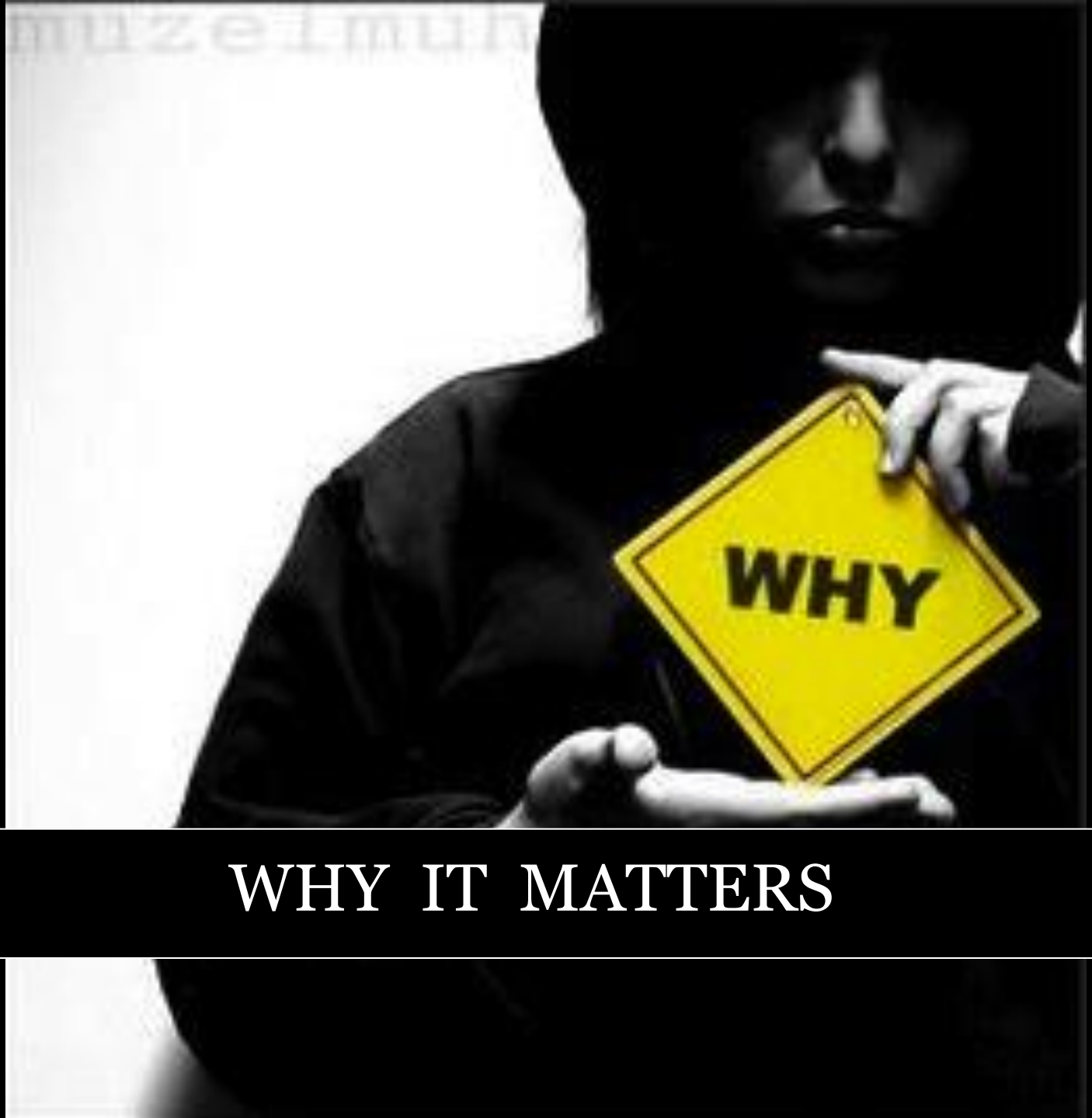
MINISTRY OF HEALTH

17/8/13

OVERVIEW



- Why this matters (*The Burden & Benefits*)
- What we know (*The Evidence)*
- Diabetes and CVD as examples
- Managing long-term conditions effectively
- Dialogue & Discussion



WHY IT MATTERS

Global Burden of Long Term Conditions

- **65%** of all deaths
- **35 million** deaths in 2010
- Increase by **17%** over next 10 years
- **75 %** of health care costs

AN INTERNATIONAL PRIORITY

WHO target (May 2013):
"To reduce premature deaths from NCDs by 25 per cent by 2025"

MINISTRY OF HEALTH
MANATŪ HAUORA

AN INTERNATIONAL PRIORITY

INCLUDES:

10% relative reduction in diabetes prevalence

40% relative reduction in tobacco use

0% increase in obesity prevalence

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

MINISTRY OF HEALTH
MANATŪ HAUORA

DIABETES - WHAT WE KNOW

7% **OF ADULT POPULATION**

(But higher for Māori, Pacific & Indo-Asian)

MINISTRY OF HEALTH
MANATŪ HAUORA

DIABETES - WHAT WE KNOW

8%

ANNUAL GROWTH RATE

(Diagnosed diabetes 2006-2012)

DIABETES - WHAT WE KNOW

GREATER IDENTIFICATION
MORE EFFECTIVE INTERVENTION
MORE EFFECTIVE MANAGEMENT

FUTURE CHALLENGE:
BETTER PREVENTION

DIABETES - WHAT WE KNOW

OUR LARGEST,

FASTEST GROWING

HEALTH ISSUE

MOST PEOPLE
HAVE NO IDEA THEY HAVE DIABETES

MOST PEOPLE HAVE NO IDEA THEY HAVE DIABETES

"I didn't know I had diabetes.

It was back in 2003. I felt a bit unwell one night and went to after hours.

I ended up going in to hospital to have a gall stone removed and while I was there they discovered I had diabetes as well."

Joseph, Christchurch.

DIABETES - WHAT WE KNOW

HOWEVER…

WE ARE IDENTIFYING EARLIER & ACHIEVING GREATER CONTROL AFTER DIAGNOSIS

MINISTRY OF HEALTH
MANATŪ HAUORA

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%

MAKING MANAGEMENT OF LONG-TERM CONDITIONS EASIER

DIABETES – POPULATION MANAGEMENT APPROACH

- **Identification:** ***More Heart & Diabetes Checks***
- **Management:** ***Diabetes Care Improvement Package***
- **Prevention & Management:** ***Green Prescriptions***

DIABETES CARE IMPROVEMENT PACKAGES

- Intended to cover all people with diabetes
- More than Annual Checks but these can be a useful tool
- Equity of access
- Access to all relevant care (retinal screening, podiatry etc)
- Self management support/ groups
- Secondary support to primary care
- Workforce development
- Feedback/ CQI/ Clinical Governance

PEOPLE NEED HELP TO MANAGE
ESPECIALLY AT THE BEGINNING

PEOPLE NEED HELP – ESPECIALLY AT THE START

"At the start, when I needed it, they helped manage me. I'm pretty much self-managing now but I couldn't' have done it without the support I had.

I feel like I've been really well monitored – without the meds my quality of life would have been rotten.

Now I can say there's definitely life after it!"

Alan, Hawera.

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*

CVDRA

- *Target tick boxes or useful activity?*
- *Supporting population management*
- *Supporting appropriate assessments for people to allow risk management*
- *A great demonstration of what general practice/ primary care can achieve*

CVD - WHAT WE KNOW

- Each year, a practice with around 10,000 patients sees approx 14-15 deaths
- Of the 10 CVD deaths, 3-5 are typically ‘premature’ and potentially avoidable

PEOPLE NEED HELP – ESPECIALLY AT THE START

"It's a real challenge. Most of us have very low understanding of medical language.

One moment you're just living your life and the next you've been diagnosed with a condition and people are talking to you using terms you just don't understand. Let alone the various medications.

There's a lot people could do to make the journey easier and less intimidating."

Margaret, Kapiti Coast.

LIFESTYLE CHANGE IS DIFFICULT

WITH SUPPORT PEOPLE CAN SELF-MANAGE EFFECTIVELY

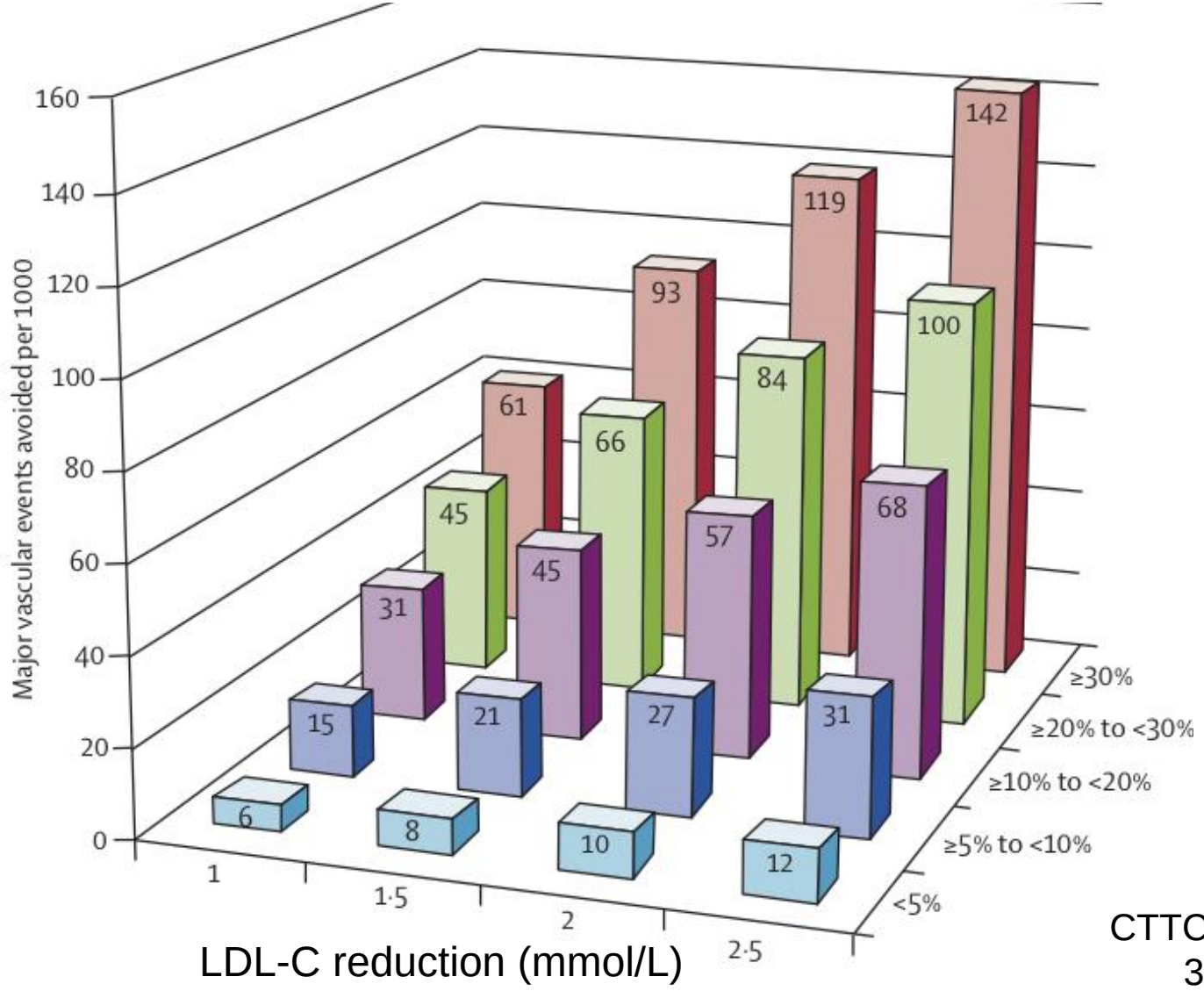
"I truly think and feel that I am in better health for having been diagnosed than I might have been.

It led me to actively manage my own health and wellbeing. It motivated me to keep to a healthy level of physical activity and manage what I eat.

I know I'm the better for it and I'm extremely grateful for that."

- **Margaret, Kapiti Coast.**

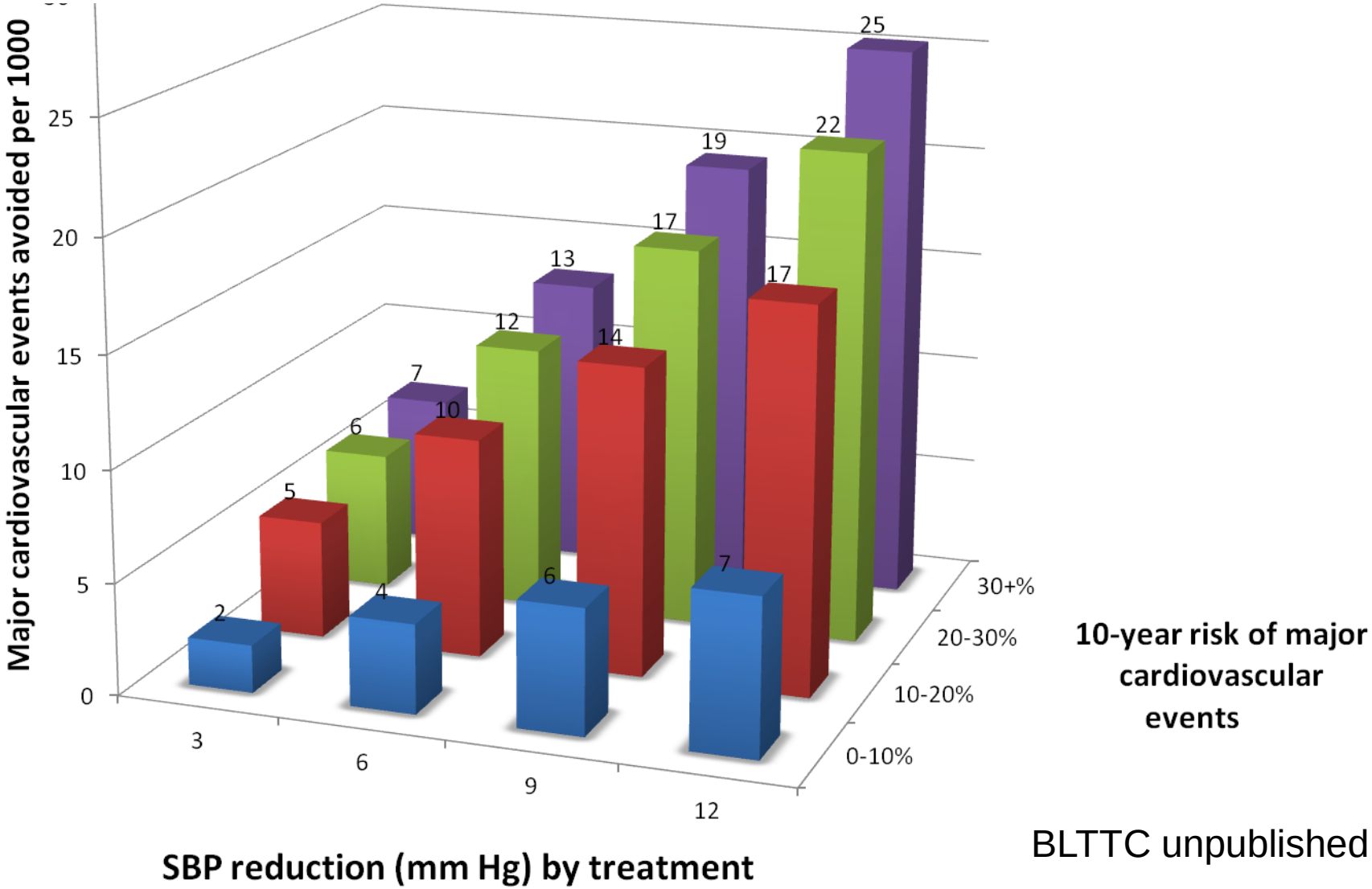
Predicted benefits of increasing LDL-C reductions with statins by baseline absolute CVD risk: vascular events avoided per 1000 treated for 5 yrs



CTTC. Lancet 2012; 380:581-90

Predicted benefits of increasing SBP reduction with drugs by baseline absolute CVD risk:

CVD events avoided per 1000 treated for 5 yrs



BLTTC unpublished 2013

Characteristic of a high performing chronic care system (Ham, 2010)Extent to which present in NZ

1. Universal coverage : *Fully*
2. Care free at the point of use or at a cost that does not act as a major deterrent to use: *Largely*
3. A delivery system that focuses on the prevention of ill-health and not just the treatment of sickness (e.g. encouraging secondary preventive activities through the payment system) : *Partially*
4. Priority is given to patients to self manage their conditions with support from carers and families: *Partially*
5. Priority is given to primary health care, particularly multi-disciplinary team work in chronic care led by nurses: *Partially*

Characteristic of a high performing chronic care system (Ham, 2010)Extent to which present in NZ contd

6. Population management is emphasised by stratifying people with long term conditions according to their clinical risk and supporting them commensurately : *Partially*

7. Care is integrated so that primary health care teams can access specialist advice and support from outside primary care, when needed:

   Partially

8. Information technology is used to improve chronic care (e.g. to facilitate communication between different professionals and to enable people to be supported at home through telecare and telehealth): *Partially*

Characteristic of a high performing chronic care system (Ham, 2010)Extent to which present in NZ contd

9.Care is effectively coordinated, particularly for people with multiple conditions who are at greater risk of hospital admission, including across the health and social care (disability support) divide (e.g. through providing care coordinators, giving people their own budgets for care and/or allowing them to make direct payment for services)

To a very limited degree

10. The other nine characteristics are linked into a coherent whole as part of a strategic approach to change that addresses several characteristics at the same time

Not present explicitly

MAKING MANAGEMENT EASIER

We need to aim for three things :

- ***Improve the health of the whole population***
- ***Improve the patient experience & outcomes***
- ***Reduce and control costs***

- *Co-morbidity is common so person focused assessments are more important than disease focus (Starfield)*

MAKING MANAGEMENT EASIER

RESTRUCTURING HEALTHCARE

- ***Need for sustainability***
- ***Overall systems change required***
- ***Can build on what is in place***

Something missing?

MAKING MANAGEMENT EASIER

PATIENT EXPERIENCE:

- **Patient centred**
- **Shared decision making**
- **Self management support**

MAKING MANAGEMENT EASIER: WHAT WORKS?

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

MAKING MANAGEMENT EASIER: WHAT WORKS?

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

MAKING MANAGEMENT EASIER

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.***

MAKING MANAGEMENT EASIER: WHAT WORKS?

QUALITY IMPROVEMENT

- Data clean-up, recording and reporting (Identifying people not receiving care)
- Real-time feedback of data and status in relation to ‘target”
- Regular reporting and discussion at practice meetings
- Practice quality plan

FOR DISCUSSION

1. **What is working well in your practice?**
2. **What challenges do you face?**
3. **What support do you need?**