

Diabetes, CVD, & Smoking: Managing Long-term Conditions Effectively

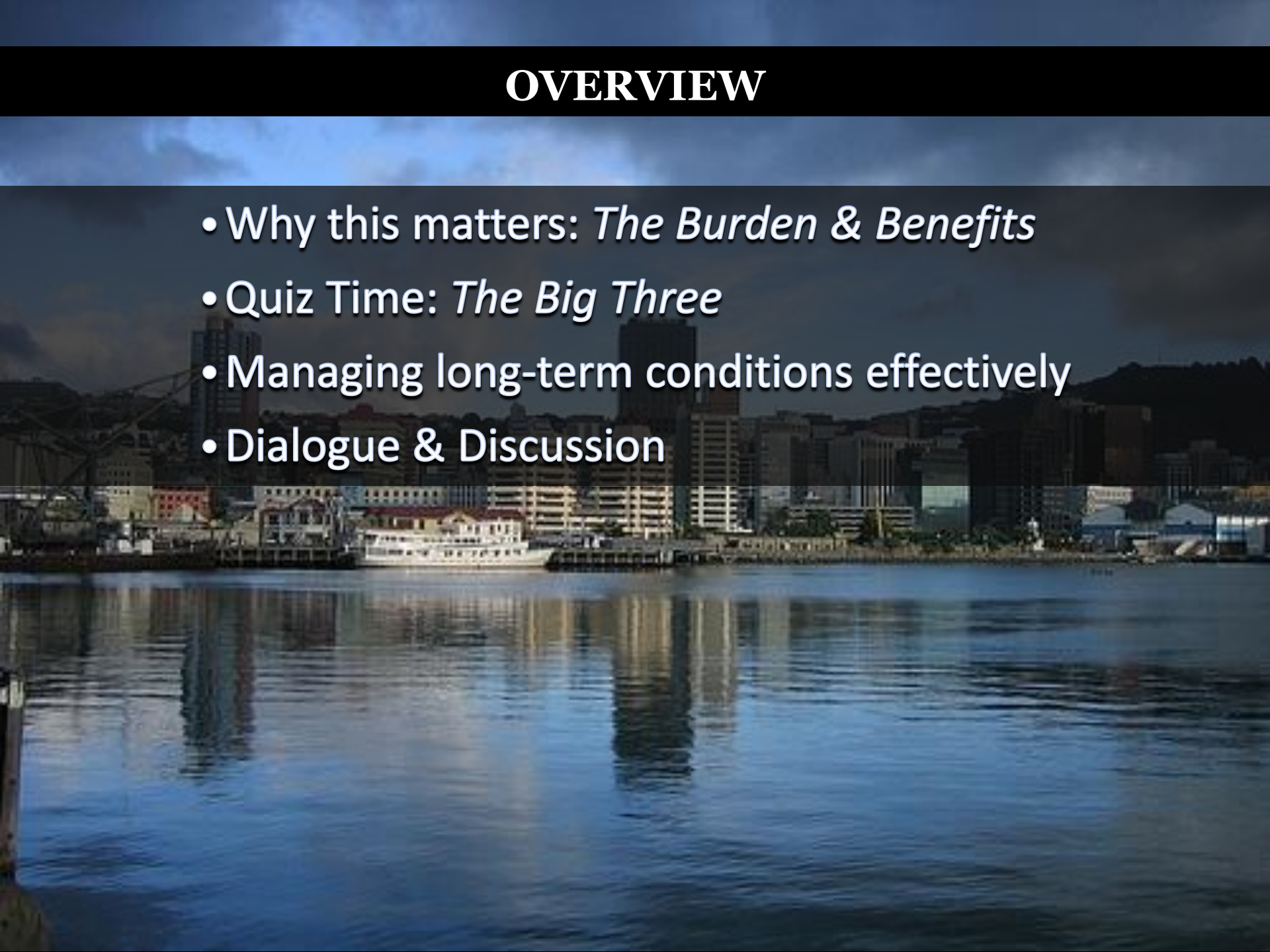
Helen Rodenburg

MINISTRY OF HEALTH

17 Aug 2013

OVERVIEW

- Why this matters: *The Burden & Benefits*
- Quiz Time: *The Big Three*
- Managing long-term conditions effectively
- Dialogue & Discussion



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**
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AN INTERNATIONAL PRIORITY

WHO Target (May 2013):

*To reduce premature deaths from NCDs
by 25 per cent by 2025*

AN INTERNATIONAL PRIORITY

INCLUDES:

10% relative reduction in diabetes prevalence

40% relative reduction in tobacco use

Zero 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
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THE BIG THREE

DIABETES

1. How many people are currently diagnosed with diabetes in NZ?

225,000



2. How many people are believed to have 'pre-diabetes' ? (*HbA1c 40-49*)

500,000

3. How many CVD & diabetes checks are being recorded each quarter?

45,000 (107,000 last quarter)

CARDIOVASCULAR DISEASE

1. CVD accounts for approximately what percentage of deaths per year in NZ?

40%



2. A practice with around 10,000 enrolees sees about 14-15 deaths each year.

How many of these are due to CVD?

10 (70%)

3. Of these, how many would be considered premature, preventable deaths?

3-5 (30-50%)

SMOKING

1. What proportion of NZers smoke?

21%

2. How many NZers die specifically from smoking-related causes each year?

4,500 – 5,000

3. What percentage of smokers have been trying to quit in the last 5 years?

60%



MAKING MANAGEMENT EASIER

We need to aim for three things :

- 1. Improve health and equity for all populations***
 - 2. Improve quality, safety and experience of care***
 - 3. Best value for public health system resources***
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Characteristic of a high performing chronic care system (Ham, 2010)

1. Universal coverage
2. Care is free at the point of use or at least at a cost that does not act as a major deterrent to use
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)
4. Priority is given to patients to self manage their conditions with support from carers and families
5. Priority is given to primary health care, particularly multi-disciplinary team work in chronic care led by nurses

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

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)
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

*“Co-morbidity is common,
so person focused assessments
are more important than a disease focus”*

- Starfield

LIFESTYLE CHANGE IS DIFFICULT



*This is not a box-ticking exercise.
It's about saving lives*

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.

*“Possibility is not a prediction or a goal.
It is a choice.”*

- Peter Block

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
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NEWS





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Shorter Waits for Cancer Treatment

More Support for the Primary Care Targets

posted by Danielle Crooks on 25 Jul 2013

There has been a tremendous amount of hard work go into the Better help for smokers to quit target in...

The Well Child/Tamariki Ora Quality Improvement Framework

posted by HIIRC Admin on 29 Jul 2013

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FOR DISCUSSION

- 1. What is working well in your practice?**
 - 2. What challenges do you face?**
 - 3. What support do you need?**
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FEEDBACK, DISCUSSION & QUESTIONS:

