Improving Wellbeing: Models of Care for Long Term Conditions

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MINISTRY OF HEALTH

GPCME

June 2015
Outline

• Why the need to change
• Long term Conditions context
• About practices, people and systems
• Activated healthcare, activated people
• Examples
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
Rationale for MOH work

The principal aim of this work is to support clinical integration by strengthening primary care and enable the whole system to adapt to the challenges of:

• Aging populations
• Increasing chronic conditions
• Tighter fiscal environments
• Variation in practice
• The need for consistent Quality, Safety and Access for all Nzers

*New health strategy pending*
Mortality Amenable to Health Care

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
• Different trajectories with different morbidities
• Inequalities in prevalence and outcome
Equality vs Equity

- Equality doesn’t mean justice
- This is equality
- This is justice
Diabetes Prevalence

In the last year the number of people with diabetes grew by 17,400, which equates to nearly 50 people per day.
Health of people with severe mental illness

Heart disease – death rate 2.2 times rate of general pop
Influenza deaths – 5 times
Cancer – Service users have a death rate 1.5 times
Diabetes – death rate 3 times
Respiratory illness deaths – 2.8 – 4 times
20% shorter life expectancy
Substance and alcohol problems

www.tepou.co.nz/equallywell
What are we working on for Models of Care...

Yet to be described for our system - project outline

High-level strategic direction

NZ Health Strategy & Triple Aim
Primary Health Care Strategy

Picture of future P&CHC state

Models of Care characteristics and success factors that define the future state

Making the change

What needs to happen and who needs to be involved

Interventions

BSMC BC
Alliancing
IPIF
Option 1
Option 2

Remain fit for purpose

Good solutions emerging
Draft model

Person centred

Reflective of community needs, resources and culture

Team based approach
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.”
Population need

Case management

Disease management

Self care support/management

level 3
high complexity

level 2
high risk

level 1
70-80% of CDM population
Evolved Chronic Care Model

Community
- Build healthy public policy
- Create supportive environment
- Strengthen community action

Health System
- Self management/develop personal skills
- Delivery system design/re-orient health services
- Information systems
- Decision support

Activated community
- Informed activated patient
- Prepared proactive practice team
- Prepared proactive community partners

Population Health Outcomes/functional & clinical outcomes

Core concepts after Stott and Davis
personal consultation model
Patient Engagement in Care Management for Chronic Condition

Source: 2011 Commonwealth Fund International Health Policy Survey in Eleven Countries
Data collection: Harris Interactive, Inc.
Patient Engagement in Chronic Care Management, Among Adults Age 65 or Older

Percent who have a chronic condition and:

- A health care professional discussed their main goals and gave instructions on symptoms to watch for in the past year
- Had a treatment plan for their condition they could carry out in their daily life

Source: 2014 Commonwealth Fund International Health Policy Survey of Older Adults in Eleven Countries.
Some other comparisons for New Zealand

<table>
<thead>
<tr>
<th>Topic</th>
<th>2008</th>
<th>2011</th>
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</thead>
<tbody>
<tr>
<td>Experienced medical, medication or lab test error in past 2 years</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>Experienced coordination problems with medical tests/records in past 2 years</td>
<td>21%</td>
<td>15%</td>
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Overall in 2013 NZ was 2\textsuperscript{nd} for coordinated care
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”
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.
What do you need to manage LTC more effectively?

Activated Practices:

✓ Information available at the time of patient contact to support best practice care including recall, decision support

✓ Accurate coding that identifies all long term conditions

✓ Audit and feedback to support best practice / Clinical Governance

✓ Flexibility with patient management- high tech/ “low touch” vs “high touch”

✓ Good teamwork

✓ An established structure for managing Long Term Conditions that supports proactive care
What do we need to consider?

• Funding and/or clinical models used to offer structured care
• Wrap round services provided by PHO
• Multi channel systems to support communication, recall and management
• Links with local communities and workplaces
• Psychological support
Activated people -Self Management

☑ Helps people develop the knowledge skills and confidence to manage their own health

☑ Can improve self esteem and confidence to perform tasks of every day life

☑ Can reduce attendance in primary and secondary care

☑ Can be one on one (motivational interviewing, health coaching, behavior change etc)

☑ Group (Stanford model widely used)

☑ Health literacy an important component

☑ Peer learning and support
What do we need to consider?

Patient experience:

- Patient centred, whanau, social context
- Mental health
- Shared decision making
- Self management support, including community
- Health literacy
- Use of technology
“Patient Activation”

• Health literacy targeted interventions can improve safety, satisfaction and reduce hospitalisation.  

• Interface with health professionals: “What matters to you”

• Specific Community support

• Self management groups eg Stanford- effective for people with mental health problems

• Support groups

• Peer support (mental health evidence)

• Pre-existing skills and need to reduce disparities

1.Integrating health literacy with health care performance DeWalt and McNeill 2013
Self management and LTC

Examples:

- Hauraki PHO: Kaiawhina practice nurse partnership enabling improved health
- Practices running groups eg for prediabetes
- PHOs taking proactive approach to self management eg supporting Stanford courses
- Healthy Village Action Zone- parish nurses PHO/church approach
- Care Plus and other LTC models
Long term mental health problems

• Addressing access barriers-
• Managing the physical and psychological care of people with stable conditions, or when new issues arise

• Long term conditions management programmes, including nurse led clinics
• Support for self management, healthy lifestyle
• Regular audits of care
Holistic approach but don’t forget other Long Term Conditions

- Chronic Kidney Disease
- Arthritis
- Cardiac conditions eg Atrial Fibrillation
- Neurological conditions
- ADHD
- Schizophrenia
- Bipolar Disorder
Chronic Kidney Disease: Enablers/monitoring

Software based decision support, audit and recall systems for best practice. Bpac tool to be available

Example: Nurse-led clinics to manage high risk CKD patients
A primary care nurse managing a group of high risk CKD patients through regular clinics:
• that are identified in the primary care practice
• using an individualized programme with each patient
• supported by specialist secondary care nursing,
• as well as both primary and specialist medical expertise
• aiming to improve identified risk factors for these patients.
Discussion

What will help in your practice / community to improve care for people with long term conditions?