CCM – Chronic Care Management
LTC – Long Term Conditions

CVD ACTION PLAN (C&C DHB)

The table below indicates activity intentions, using a systematic approach based on Wagner's CCM Model (1999) adapted for C&CDHB.

(Funding Dependant)

Activity		Community Including: Community resources and policies	Health System Including: Patient safety	Self Management Support	Delivery System Design Including; Cultural competence Care Coordination Case management	Decisions Support and Clinical Information Systems	Timeframe
Planning Information Evaluation	1. Maximise consumer and community partnership	Build on current work with PHOs, iwi, churches and NGOs to engage communities in planning CV Risk & other programmes	Maintain CVD as a priority in DHB across whole system including: Public health, primary care, secondary care & support services through primary & secondary clinical governance, EMT, DAP process	Care Plus/Hand Held Records and other resources to support self /whanau management	Strengthen Community participation in PHOs and links with DHB to inform planning, public health intervention and social marketing across different groups at high risk of CVD		Ongoing + Annual review through monitoring framework
		Report back to community re progress in CVD prevention & service impacts through newsletters, email, network & community visits,		Utilise community groups as an asset in developing appropriate resources	Develop mechanisms for community feedback to PHOs and DHB about CCM –what works, what doesn't, gaps,		Ongoing

		Local Govt, KCHG, Board committees, Porirua Healthlinks			improvements		
	2. Prioritise high risk groups & Joint planning		Use District Plans, Health Needs Assessment (DHB), PHO plans, PHO performance framework, monitoring reports, reviews and evaluation of impact of CVD investment to inform planning & prioritise CVD work				Dec 2008
					Establish primary/secondary clinical interface governance structure		June 2008
		Support Social Marketing effective for highest risk populations Public health measures to reduce CVD prioritised for Porirua, Maori, Pacific, low income, Indian sub continent	Monitor access of high risk groups + outcomes for high risk groups in health system for CVD (and share this information with primary & secondary clinical interface governance)	Resources in appropriate languages & formats for high risk groups & with community input re appropriate formats	Improve access to primary care & other services for Maori, Pacific, low income populations & other groups at higher risk of CVD	Explore options for Practice Information Systems Software for decisions support in PHOs DHB, PHO, providers' data for monitoring access + progress in CV Risk Assessment . Ethnicity to include	By Dec 2008

		communities				Asian & sub categories	
				Improve linkage into planning of NGOs eg Stroke Foundation, Te Hotu Manawa Maori, National Heart Foundation (NHF), Pacific Heartbeat etc			By June 2009
	3. Information & support	Increase DHB & provider understanding of community assets and resources through stocktake & other mechanisms		Stocktake of current information and support services Identify key gaps in information and support for people with CVD		CVD risk profiles in PHOs monitored and information & planning	By June 2009
					Ensure key referral processes for CVD are agreed and in place (primary & secondary endorsement), links with GP liaison, Maori Navigation Project, primary/sec joint clinical interface governance etc		By June 2009
Prevention Primary and Secondary	1. Promote healthy lifestyle using priority	Continue active input into urban planning in Porirua (Cannons Creek)		Support and opportunities for healthy living for all populations	Support systematic CVD Risk Assessment programme and	Integrate evidence base for prevention into all levels of health system	

	population approach + action to reduce barriers, and create supportive environments	- Kapiti Physical Activity Strategy - Wellington Regional Strategy (At the Heart) Action through PHOs and Regional Public Health and community based groups		including low income populations: PHO actions, DHB/Intersectoral actions to increase income/employment + reduce barriers to healthy lifestyle	access to appropriate Interventions	including: secondary prevention eg. Cardiac rehab. CV Risk established 50% coverage high risk groups by	By June 2008 By June 2010
		Implement C&C DHB Population Health Plan, C&C DHB 5 year strategic plan, C&C DHB Tobacco Control Plan -Youth	Regional Public Health Strategic Plan & joint planning with RPH & other public health providers through shared public health physician and other mechanisms				Established by Dec 2008
		Support health promotion, prevention & early interventions that will work for Maori	Plan for expanded Cardiac Rehab				By Oct 2008 Te Plan II
			Support Rheumatic Fever prevention programme in appropriate communities				By June 2009
		Implement C&C DHB Population Health					By June 2009

		Plan, C&C DHB 5 year strategic plan, C&C DHB Tobacco Control Plan C&C DHB Tobacco Control Plan including smoking cessation support					
		Maori development and intersectoral support for healthy Maori communities	Increase access to statins for Maori through CV risk Assessment and workforce development plus feedback mechanisms of DHB level monitoring (Also see Diabetes Action Plan)			Influence weighting of risk and scoring for interventions for Maori Monitor uptake of high risk groups of CV risk Assessment and CVD programmes	Implement Te Plan II 2007 -June 2012 By June 2010
		Reduce CVD in Pacific populations	(Also see Diabetes Action Plan)			Monitor uptake of high risk groups of CV risk Assessment and CVD programmes.	By June 2010
			Promote Pacific led primary care and access to primary care for all Pacific population		Develop linkages through Pacific service in hospital with CVD programmes in community		Ongoing 2008-10 + PSAP

					Continue to develop Pacific specific approaches to reducing stroke and CVD		
		Indian sub-continent	Prioritise for CV risk assessment in phase 2 of CV Risk programme	Develop appropriate resources re CV risk and reduction of risk		Monitor uptake of high risk groups of CV risk Assessment and CVD outcomes with subpopulation data	By June 2010
		Work to reduce CV risk in other high risk groups	(Also see Diabetes Action Plan)	As above	Improve access to cardiovascular services diagnostics and interventions for high need populations. Monitor access and outcomes by age, gender, ethnicity, NZDep where feasible	As above	By June 2010
	2. Resources		Joint planning with Public health services and input into public policy that supports prevention focus Increase access to appropriate resources – nutrition, physical activity,	Strengthen Peer support groups, services and access to information, early advice to prevent and or delay development of CVD		Distribute or make available evidence to inform interventions. Utilise MSD Social indicators report Ministry of Health &Public Health Intelligence. And other monitoring to	By Oct 2009

			medication, and psychological support			track progress in relevant indicators	
			Public policy & action with local Govt, MSD & other agencies to support prevention including access to affordable recreation and physical activity, income to support good nutrition				On going 2008-10
		Support consumer friendly information sources and support –for individuals, families, different populations Work with communities to improve availability of appropriate resources			Develop & distribute culturally appropriate information and services. (Pacific, Asian, Other ethnic groups, youth, older people)		By Oct 2009

Early identification	1. Raise Awareness	Increase knowledge within communities of CVD, how to reduce risk, how to get optimum care + outcomes eg with NHF, Te Hotu Manawa Maori, Pacific Heartbeat, PHOs, PHARMAC, Iwi * community groups					Ongoing 2008-10
	2. Increase Access	Increase access to screening opportunities and available information in multiple community settings and multiple languages	Joint primary/secondary clinical interface governance structure in place, PHOAG, + Working Parties with specific focus on service improvements	Include families/whanau in 'Self' management to increase awareness in higher risk whanau Support CV risk assessment for relevant family members of people with CV events	Hospital link back into PHOs & primary care, NGOs to support family/whanau engagement following admission	Information shared across HHS, primary care systems re family history & risk of CVD to support tailored information & risk assessment in family members of people with MI, Stroke etc	By June 2011
			Support routine (opportunistic and programme) CV risk and diabetes screening for 'At risk' groups		Strengthen design elements that facilitate access in high risk populations and reduce barriers for all people to primary care & diagnostics		By June 2009
		Inform community of availability of	Increase access to screening and		Review pathway of referral for	Monitor trends in access	Use 07/08

		screening programmes through newsletters, PHOs, local Govt, GGOS, Churches, CAB etc	diagnostics for groups with lower access and high risk of CVD		diagnostics to improve timely, affordable access to diagnostic procedures	disaggregated by age, ethnicity, gender, NZ Dep and where possible TLA Use data re utilisation at primary care level Screening coverage data Trends in CVD Assessment, morbidity & mortality	baselines. Increase by June 2009
		Improve access to effective treatments for Maori					By 2010 Te Plan II
Optimal Treatment & Management	General		Joint primary/secondary clinical interface governance structure in place				By June 2008
			Gap analysis, prioritisation for funding and new initiatives or service reconfiguration	Decision making tools in place		Referral /Exit criteria & protocols in place for outpatients	June 2009
			Support -Evidence based practice -Audits at practice		Development, implementation and monitoring of clinical pathways and guidelines –		Ongoing 2008-10

			level - Workforce Development- - Distribution of relevant resources -Resources and systems to reduce adverse CVD events in hospital and primary care Implement relevant QIC initiatives. (Links to national Quality Improvement Initiatives)		agree 2-3 priority areas for joint work across primary & secondary + monitor Acute care pathways and multidisciplinary guidelines – endorsed by both primary and secondary Support best use of existing systems, resources, workforce, skills Initiatives to improve coordination across services and "the Patient Journey"		
		Increase availability of consumer information about optimal care, care options, service options	Improve access to information and affordable primary care Improve access to Diagnostic interventions, laboratory services, specialist consultation, specialist nurses and specialist allied health	Increase understanding & use across entire health and community sector of the importance of resources and support for individuals and families living with CVD to enable optimal self/whanau management through: - training	Resource allocation that recognises the importance of prevention and as a key focus of health service delivery. Support & increase Care Plus uptake, Optimal primary care for CVD including: -Hypertension treatment -Statins	Primary care information systems to support optimal treatment for CVD - recalls - Decision support - audits Shared patient information through EHR	June 2010

			Improve access to appropriate resources – nutrition, physical activity, rehabilitation, psychological support, family/whanau support Disability support aids and equipment Audits, clinical governance	opportunities - resource availability	-Post MI treatment -Atrial fibrillation treatment -Stroke protection after Transient Ischaemic Attacks (TIAs) Improve linkages between primary care, NGOs, support groups, field workers, Care Coordination Centre, Palliative services		
	CV Disease generally & Cardiac Rehab		Cardiac Rehab - expand & increase participation, use 2007/08 baselines		Support & increase cardiac rehab service		By June 2009
			Increase access to CABG/angioplasty for Maori	Support whanau models of care			Implement Te Plan II By 2012
	CVD Risk	Improve access to income and utilise other mechanisms to ensure access to early diagnosis and treatment options for people on low incomes with CVD	Increase Statin uptake in high risk groups using 2007/08 baselines		Audit CV risk assessment and management of people with CVD risk. Improve assessment & management of CVD in people with		By June 2010

					mental illness		
	Heart Failure		Expand Heart Failure Service across DHB		Support & increase Heart failure project capacity		By 2010
	Rheumatic Fever	Reduce Rheumatic Fever in children through specific public health action			Continue to support Rheumatic fever service for youth follow up (secondary prevention)		2008-10
	Stroke				Improve TIA follow up & appropriate investigation/ medication especially for high risk groups		2008-10
					Reduce strokes and readmission rate for stroke for Maori and Pacific through system review and redesign		Implement Te Plan II Implement Pacific Plan By 2010
					Stroke service established in HHS		By June 2009
					Increase Care Plus uptake for Maori and Pacific people		By June 2009
						Agreed Referral /Exit criteria & protocols in place for	2008-10

						outpatients	
Equity Reducing disparities	1. Reduce impact for Maori	Reduce CVD for Maori population through specific investment for appropriate interaction Support health promotion, prevention & early interventions that will work for Maori	Establish joint primary/secondary clinical interface governance structure in place with a focus on equity of access + outcomes Increase access to CABG and angioplasty for Maori Reduce strokes and readmission rate for stroke through system review and redesign		Reduce disparities between Maori and non-Maori in CVD , detection rate, annual checks, referral, Care Plus, primary care access Support innovative Maori specific approaches to improve access to CV services (secondary & Tertiary) – Navigator project & other initiatives	Increase Care Plus uptake for Maori people with diabetes, CVD	Ongoing Te Plan II
	2. Reduce impact for Pacific	Reduce CVD for Pacific populations through specific investment in appropriate interventions	Promote Pacific led primary care and access to primary care for all Pacific population		Develop linkages through Pacific service in hospital with CVD programmes in community Continue to develop Pacific specific approaches to reducing stroke and CVD	Reduce admissions amongst Pacific populations	Ongoing 2008-10 + PSAP
	Other high risk populations	Reduce CVD for Indian population through specific	Prioritise Indian population for CV risk assessment in	Develop appropriate resources for Indian population re CV risk		Monitor uptake of high risk groups of CV risk Assessment	By June 2010

		investment	phase 2 of CV Risk programme	and reduction of risk		and CVD outcomes with subpopulation data	
		Reduce Rheumatic Fever in children through specific public health action			Improve access to services across entire health system increased for high need populations Monitoring of access and outcomes by age, gender, ethnicity, NZDep where feasible Utilise community participation to inform design. Strengthen mechanisms for consumer and community input Support Navigation projects and action research		Ongoing 2008-10
Workforce			Primary /secondary clinical interface governance structure in place Support specific focus on workforce development to improve management of				By Oct 2008

			long term conditions				
		Public health workforce Health promotion capacity in PHOs, working with communities & intersectorally		Support Self management training for workforce including structured patient self-management training and whanau models	Support for: Adequate, skilled workforce. Effective, multidisciplinary teams Primary care-general practitioners, nurses, allied health Community support workers, link workers, interpreters providing culturally competent care. Support models that recognise multidisciplinary team approach, time for CCM type of care, case review - Secondary care Consultants Specialist Nurses Diagnostic capacity		By June 2011

					Workforce development opportunities		
			Workforce training in cultural competence, clinical care, self/whanau management	**Support for consumer groups, peer-led support**	**Upskill & develop capacity in current providers** **Support workforce with ability and willingness to work across a variety of settings**	**Appropriate decision support tools/information** **Feedback to practitioners and teams of relevant information, audit, review through PHO clinical governance groups, 6 monthly DHB progress reports and other reviews**	**By June 2011**
			Increase the number of Maori in the Health & Disability workforce				**Ongoing** **By 2010** **Te Plan II**
			Recruit, retain & develop Pacific Staff within C&C DHB and the provider arm				**Ongoing** **2008-10** **PSAP**

Medium term outcomes
♣ **Reduced smoking rates** ♣ **Reduce obesity** ♣ **Increase physical activity** ♣ **Increase flu & pneumococcal immunizations** ♣ **Reduce avoidable hospital admissions** ♣ **Reduce cardiovascular disease (strokes, heart attacks etc..)** ♣ **Improve quality of life for people with CVD** ♣ **Reduce mortality from CVD** ♣ **Reduce disparities in CVD outcomes** o **Increased access for Maori, Pacific & low income populations** ♣ **Increase % of people participating in:** o **Regular physical activity** o **Self/whanau management** o **Weight control strategies** ♣ **Increase of Cardiovascular risk Assessment matched to baselines and MOH Model** ♣ **Increase from baseline at 'Stocktake' in number and range of self management groups** ♣ **Increase in disability allowance volumes and disability support access.** ♣ **Standardised decision making tools**