Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

SUMMARY DOCUMENT
LONG TERM CONDITIONS (LTC) MANAGEMENT FRAMEWORK

MARCH 2008

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PURPOSE OF THIS DOCUMENT

This document is a summarized version of the Long Term conditions management Framework document

1. INTRODUCTION

The prevalence[1] of and number of admissions for chronic diseases has risen significantly over the last decade. The World Health Organisation (WHO, 2002) defines chronic conditions as "health problems that require ongoing management over a period of years or decades". WHO reports that chronic conditions are estimated to account for the majority of premature deaths and up to 70% of all health expenditure, and have become one of the greatest challenges facing health care throughout the world. Despite this, most hospital and primary care services are designed in accordance with episodic and acute models of care designed for infectious disease.

In New Zealand, we can take learning's from strategies implemented in other countries to manage chronic conditions and add in a strengths-based approach which recognises the assets, expertise and resilience in people, families and communities, incorporates social justice and whanau ora dimensions. This local approach aims to provide people with effective support and guidance to be enable them to have and make the right choices for themselves and their whanau/family.

Our Capital & Coast District Health Board (C&C DHB) Health Needs Assessment (HNA, 2003), identified several population groups within the Capital and Coast district that have particular and high health needs. With a coordinated approach we can positively influence incidence[2] of chronic conditions, and improve the life of people living with chronic conditions, by working across the whole spectrum from prevention to palliation.

The overall goals of this work are to:

- **reduce illness and disease among high health need populations,**
- **reduce the number of people who develop an on-going illness or disease and when an illness or disease does develop and,**
- **reduce the impact on people's lives to maximise opportunities for independence and maintain or improve quality of life, particularly for high health need populations. (District Annual Plan (DAP), 2007-10).**

We have developed action plans with sector input. These plans build on and recognise the services and initiatives already in place. A set of indicators to monitor progress and baseline values are included.

The potential scope of activity to reduce the incidence and impact of long term conditions is enormous. The framework and action plans acknowledge existing work and services, attempting only to identify key areas of joint focus over the next three years.

2. C&C DHB LONG TERM CONDITIONS (LTC) MANAGEMENT FRAMEWORK

[1] Prevalence – the number of people with a disease at any one time.
[2] Incidence – new cases of the disease

The development of the LTC management framework and action plan originated from the C&C DHB Executive Management Team. The LTC management framework document provides a realistic and transparent framework to explicitly outline key priorities, provide a feasible set of actions, and establish overarching service strategies to achieve our goals for the next 3 years. It is designed to inform direction and work of C&C DHB and its partners in health to address the prevention and management of chronic (long term) conditions. It recognises important related strategic and operational plans that contribute to progress in this area, including Te Plan II, Promoting participation, the Pacific Health Action Plan, HEHA plan, Cancer Control Strategy and Palliative Care planning, proposed Youth Health and Child Health Action Plans, Health of Older People Strategy, Intersectoral Strategy, The Journey Forward and others.

The Framework supports our high level outcomes to: 'Reduce Disparities in Health Status' and 'Reduce the Incidence and Impact of Chronic Disease' and is designed to inform direction and work of the C&C DHB and its partners in health to prevent and better manage long term conditions.

Our overall goals are to:

- **reduce illness and disease among high health need populations,**
- **reduce the number of people who develop an on-going illness or disease and when an illness or disease does develop, and**
- **reduce the impact on people's lives to maximise opportunities for independence and maintain or improve quality of life, particularly for high health need populations. (District Annual Plan (DAP), 2007-12)**

To fulfil our goals we must:

- **Maintain our 'Vision' (Better health and independence for people, families and communities)**
- **Implement our 'Strategies' including prevention strategies**
- **Ensure equitable resource allocation and service provision for Maori, Pacific and other high need populations**
- **Agree priorities for any new funding and our collective effort.**
- **Recognise and strengthen services and initiatives already working well.**
- **Develop mental health services including addiction treatment services, develop and improve access to primary mental health services and recognise the interfac between mental health and long term conditions/physical health.**
- **Work collaboratively and intersectorally.**

Our C&C DHB Health Needs Assessment (HNA, 2003), has identified several population groups within the Capital and Coast district that have particular health needs. These populations include Maori, Pacific, and people from areas of high deprivation, older people and children (with some sub-groups requiring high use of health services), people with disabilities, refugees, and those with serious mental health conditions. In general, these sub-populations develop chronic conditions many years earlier than the general population have a lower life expectancy, higher morbidity and mortality rates.

The HNA also gives an indication of where the changes in resources could be beneficial. A case for more effective services is indicated by health need, relative under-servicing and avoidable morbidity and mortality and may also indicate where funding could be redirected. it also provides data that is needed for prioritisation and decision making and it informs the community providing a basis for consultation.

The aims of management of LTCs are to:

- **Give quality individualised care**

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- **Earlier detection (to reduce potential complications)**
- **Treat sooner (the right care by right person in the right place)**
- **Good control to minimise effects of the condition and reduce complications**
- **Good management and reduction in crisis/exacerbations**
- **Enable and promote patient and family/whanau empowerment by supporting self management**
- **Increase life expectancy and quality of life**
- **Reduce avoidable hospital admissions and make more effective use of resources promoting integrated care**
- **Reduce premature mortality from chronic conditions.**

Our plan is mainly focused on joint work around existing programmes for process improvement, to improve outcomes and reduce disparities by: applying multi-level strategies with population and targeted approaches. We will use evidence based initiatives and innovation, focus on reducing risk factors, putting in place protective measures, focusing on early childhood and identified life course challenges and improving outcomes.

The action plans (available on the C&C DHB Website) are mainly focussed on joint work around existing programmes for process improvement, to improve outcomes and reduce disparities, informing Capital & Coast District Health Board (C&C DHB) District Annual Plans for 2008-2012.

They recognise important related strategic and operational plans that contribute to progress in this area and recognise the substantial investment, range of services and initiatives already in place and part of 'every day' business in the health sector. They will inform direction and work of the C&C DHB and its partners in health to prevent and better manage LTCs.

PHOs and other services have or will develop their own LTC Plan which will complement the DHB Plan and activities and while the aims and priorities are shared, the delivery design will be tailored for different populations and settings.

2.1. Our approach

In C&C DHB, we want to improve our ability to enhance the capabilities of individuals and their families/whanau, communities and providers to create and sustain health promoting environments, reduce social and economic barriers and enable people to be as healthy and active as possible.

The importance of 'community strength' is an essential part of building successful interventions and increasingly recognised. We want to take a strengths-based approach which recognises the assets, expertise and resilience in people, families and communities, incorporates social justice and whanau ora dimensions. This local approach aims to provide people with effective support and guidance to be enable them to have and make the right choices for themselves and their whanau/family.

2.11 Consultation and Ongoing Input

Consultation included but was not be limited to: PHOs, Hospital staff, Regional Public Health, NGO providers, Iwi/Maori providers and communities, Pacific providers/communities, interested community groups (Age Concern, Diabetes New

Zealand, etc), field workers, pharmacists, allied health professionals, community groups, consumers and families.

An initial steering group was formed to provide vision and direction for our long term condition
strategy development. Expertise across a range of stakeholders was needed at the initial stage and will be required throughout implementation.

Tasks assigned:

- Input into the LTC model and plan for implementation
- Ensure adequate consulting with others as required
- Feedback towards a final document.

This group has been superseded by a combined primary and secondary 'Clinical Interface Governance Group' that will guide the implementation of the long term conditions management programme. The PHO Advisory Group, Local Diabetes Team and other working groups will continue to provide input and oversight of different aspects of implementation.

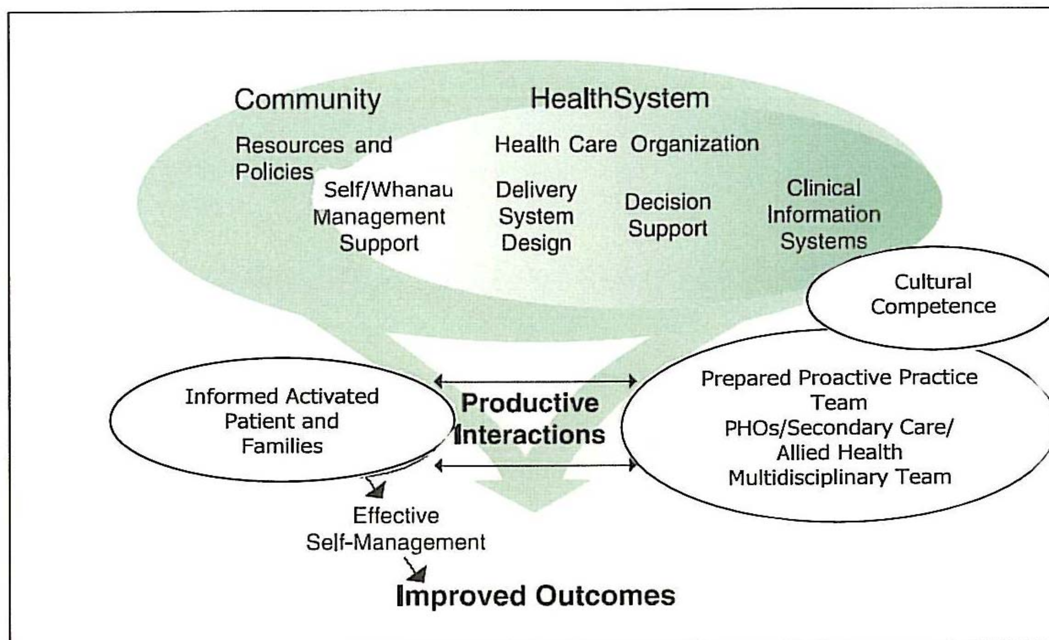
It is envisaged that the above group tasks will include:

- ensuring patient needs are represented and that community input is included
- ensuring LTC management principles are met
- take a practical – action focused approach to high level overarching primary and secondary clinical interface governance
- continuous Quality Improvement (CQI) focus

2.2 Model of Care

During initial workshops with PHOs it was suggested that C&C DHB base our framework on the Wagner (1998) 'Chronic Care Model' and adapt for the New Zealand and C&C DHB setting, incorporating a whanau ora paradigm. (See diagram below and the C&C DHB 'Communitree' Appendix 1 on page 7).
Components of the 'Wagner' (1998) Model are: Community (including community resources)
Health System (including patient safety); Self Management Support; Delivery System Design (including: cultural competence, care coordination and case management);Decision Support and
Clinical Information Systems. Within this model our activities fall into the following categories: Planning, Information and Evaluation; Prevention (primary/secondary); Early Identification; Optimal Treatment and Management and Equity (reducing disparities)

C&C DHB CCM Model (Adapted from Wagner's CCM Model, 1998)



2.3. Initial Priorities

The initial priorities are identified as: diabetes, cardiovascular disease, mental health, cancer,
respiratory, renal, information about/tools for managing co-morbidity, resources to improve self/whanau management and community-based support for all people living with LTCs.

For each of these priority conditions, key actions to be achieved over 2007-12 have been outlined. Intermediate outcomes/indicators/targets have been set, reviewing performance against them at a DHB level through six monthly reports to the Board and the community. The plans are not exclusive but identify areas where C&C DHB with other agencies, providers, consumer groups, families and communities aim through collective effort, can make improvements in services, outcomes and reduce disparities.

2.4 Stocktake

A stocktake including stakeholder analysis, will be undertaken by October 2008 in conjunction with the sector and the community. It will form a baseline for current services and initiatives.

The purpose is to ascertain and map current management of long term condition work being undertaken within C&C DHB district to identify possible links and identify any gaps to be addressed.

If you would like a hard copy of the documents, in a different format, or further information, please feel free to contact june.mcdonald@ccdhb.org.nz

The full documents including 'Action Plans' are also available on the C&C DHB Website. http://www.ccdhb.org.nz/initiatives/LTC/ltc.htm

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3. REFERENCES

1. **C&C DHB District Strategic Plan (DSP) (2007-12)** **http://www.ccdhb.org.nz/aboutus/dsp/FINAL**
2. **C&C DHB Health Needs Assessment (2003)** **http://www.ccdhb.org.nz/Aboutus/reports/HNA_2004.pdf**
3. **Wagner, E.H (1998). Chronic disease management: what will it take to improve care for chronic illness?** ***Effective Clinical Practise*** **1998; 1: 2-4.**
4. **WHO (2002) 'Innovative Care for Chronic Conditions': Building Blocks for Action", ref no: WHO/MNC/02.01.**

Appendix 1

C&C DHB Communitree