Connecting Care in NSW

Susan Burke
Chronic Disease Management Office
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Connecting Care program

- Building a service system for the management of people with often multiple chronic diseases (that impact on function) in the community

- Recommendation of Garling Inquiry
  - in response to hospital utilisation by chronic, complex and elderly patients

- Key strategy driving NSW Health Efficiency Plan - hospital avoidance program
Consistent with IPART recommendation

• Chronic diseases are best managed by systems of care that are integrated

• The primary health care sector is best placed to lead the care of patients with chronic disease

• It would be better to establish a Commonwealth driven, GP-led chronic care management strategy

• But as that is unlikely to happen IPART supported NSW Health’s proposal to introduce a State-based coordinated care arrangement for people with serious chronic diseases

• NSW Health should continue to pursue the option of a Commonwealth-driven arrangement that strengthens the role of GPs

Connecting Care program

Framework for Performance Improvement in Health, Independent Pricing and Regulatory Tribunal of NSW (IPART), September 2008
Funding

• Funding of $32.5M recurrent from 2011/12

• New budget commitment – additional $57M over 4 years

• Opportunity to fund additional clinical services – chronic care rehabilitation – and customise response to vulnerable communities
Program aims

- Reduce the **progression and complications** of chronic disease
- Improve the **quality of life** of people with chronic diseases
- Support their carers and families
- Reduce unplanned and avoidable admissions to hospitals
- Improve the health system’s capacity to respond to the needs of people with complex needs – significant micro-system reform
Selected diseases

• Big 5
  – Diabetes
  – Congestive Heart Failure (CHF)
  – Coronary Artery Disease (CAD)
  – Chronic Obstructive Pulmonary Disease (COPD)
  – Hypertension (HT)

• But recognise that patients likely to have other co-morbidities – depression, arthritis, dementia, chronic renal failure, cancer and chronic pain
More than half of all potentially preventable hospitalisations in Australia are for chronic conditions such as diabetes, asthma, angina, hypertension, congestive heart failure and COPD.
Connect Care program

Business Case

Focus of Program

Care Coordination (1:50)
- Patients have complex set of conditions, frequent ED presenter, are at VERY high risk for experiencing an acute event and need help coordinating services.
- Combination of face-to-face and telephonic support is needed.

Health Coaching (1:1000)
- Assess for referral to Care Coordinator or initiate frequent telephonic coaching, including post discharge calls
- One or more chronic conditions, frequent ED presenter or recently experienced major health event, identified care gaps, often needs pain management, medication coaching or biometric monitoring
- Focus on ensuring understanding of treatment plan and promoting healthy behaviours

Aged 65+ in NSW = ~932,000

Very High Risk

High Risk

Lower Risk

Prevention and Wellness Promotion

~2.3% 22,000

~28% 261,000

~55% 513,000

~14.7% 138,000
Target population

People with multimorbid chronic disease +/- geriatric syndromes with complex needs who are at very high risk of hospitalisation

People with established chronic disease with complex needs who are at high risk of hospitalisation

People with established chronic disease who are at low risk of hospitalisation

People at risk of chronic disease

Well population
Strong predictors - 45 and Up Study data*

- Aboriginality
- Previous unplanned admissions/ ED presentations (increasing number, increasing predictive strength)
- Diagnosis of dementia
- Diagnosed musculoskeletal condition (proxy for functional status?)
- Underweight or obese
- Low income (under $50K)
- Fair/ Poor self report health

* non-Aboriginal people over 65 yr and Aboriginal people > 45 yr
Patient characteristics associated with high health care expenditure

• Decline in functional status

• Minority race and ethnicity – patient preferences but also poor quality communication about EoL care

• Chronic conditions – diabetes, chronic kidney disease, arthritis and stroke or multiple chronic conditions (4 or more)

• Absence of carer

• Association and effect maintained with regional level characteristics that most potently influence expenditures—number of hospital beds per capita and access to hospice care

## Enrolment targets

### Connecting Care program

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Target</th>
<th>Very high</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>6,000</td>
<td>840</td>
<td>5,160</td>
</tr>
<tr>
<td>Year 2</td>
<td>15,395</td>
<td>2,155</td>
<td>13,240</td>
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<tr>
<td>Year 3</td>
<td>25,079</td>
<td>3,511</td>
<td>21,568</td>
</tr>
<tr>
<td>Year 4</td>
<td>42,938</td>
<td>6,011</td>
<td>36,927</td>
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</tbody>
</table>
Enhanced CDM model*
Comprehensive model of chronic disease prevention and management

<table>
<thead>
<tr>
<th>Well population</th>
<th>At risk</th>
<th>Established disease</th>
<th>Managed chronic disease</th>
<th>Multiple chronic diseases + complex care and support needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention</td>
<td>Secondary Prevention/ Early Detection</td>
<td>Tertiary Prevention and Management</td>
<td>Managed chronic disease</td>
<td>Continuing and supportive care</td>
</tr>
<tr>
<td>- Promotion of healthy behaviours and environments across life course</td>
<td>- Screening</td>
<td>- Treatment and acute care</td>
<td>- Subacute care</td>
<td></td>
</tr>
<tr>
<td>- Universal and targeted approaches</td>
<td>- Case finding</td>
<td>- Advance Care Planning</td>
<td>- Advance Care Planning/ End of Life decision making</td>
<td></td>
</tr>
<tr>
<td>Public health</td>
<td>- Periodic health examinations</td>
<td>- Self management support</td>
<td>- Carer information and support</td>
<td></td>
</tr>
<tr>
<td>Primary health care</td>
<td>- Early intervention</td>
<td>- Care coordination</td>
<td>- Community care</td>
<td></td>
</tr>
<tr>
<td>Other sectors</td>
<td>- Control risk factors – lifestyle and medication</td>
<td>- Complications prevention and management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared decision making</td>
<td>Primary health care</td>
<td>Primary health care</td>
<td>Primary health care</td>
<td></td>
</tr>
<tr>
<td>Public health</td>
<td>Specialist services</td>
<td>Community care</td>
<td>Specialist services</td>
<td></td>
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<tr>
<td>Hospital care</td>
<td></td>
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</table>

Population by stages of disease continuum

- Prevent movement to the “at risk” group
- Prevent progression to established disease
- Prevent hospitalisation
- Prevent progression to complications
- Prevent avoidable readmissions
- Support carers
- Support advance directives

Connecting Care program

Disease trajectory

Lynn, J and Adamson, D Living Well at the End of Life - Adapting Health Care to Serious Chronic Illness in Old Age RAND Health 2003
Clinical variation

- Lowest chronic medical admission rate (by LGA) was 1.0 per 1,000 (for people with diabetes) and the highest was 6.6 per 1,000 (for people with CAD).

- Lowest chronic medical 30-day readmission rate (by LGA) was 14.3% (for people with diabetes) and the highest was 30.1% (for people with CHF).

- The least number of days spent in hospital (by LGA) during the last 6 months of life was 14 days (for people with CAD) and the highest was 46 days (for people with CHF).
Patient characteristics - COPD and CHF PAAs

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>COPD PAAs</th>
<th>CHF PAAs</th>
</tr>
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<tbody>
<tr>
<td>Aged 85+ years</td>
<td>14%</td>
<td>34%</td>
</tr>
<tr>
<td>Aged 75+ years</td>
<td>49%</td>
<td>71%</td>
</tr>
<tr>
<td>Most disadvantaged (SES)</td>
<td>32%</td>
<td>28%</td>
</tr>
<tr>
<td>Current or previous smoker</td>
<td>59%</td>
<td>27%</td>
</tr>
<tr>
<td>Outer regional and remote</td>
<td>23%</td>
<td>19%</td>
</tr>
<tr>
<td>Aboriginality</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

- 1.8% of NSW population are aged 85+ years: 6.6% are aged 75+ years
- 20% of the NSW population is in the most disadvantaged SES quintile
- 19% of NSW people aged 16+ years currently smoke
- 2% of the NSW population is Aboriginal
- 7% of the NSW population live in outer regional and remote

Bureau of Health Information *Chronic Disease Care: A piece of the picture* June 2011
Highlights need

• Develop strategies to enable care and support for frail older people to be provided in community

• Identify triggers for referral to Specialist Palliative Care service

• Include palliative approach in workforce development strategy

• Develop and implement self management support strategies including innovative chronic care rehabilitation services

• Develop and implement self management support strategies (that can be adapted locally) to reach disadvantaged (SES) and outer regional and remote populations

• Identify strategies to engage Aboriginal communities in improving access to out of hospital services and self management support

• Consider developing and implementing speciality clinical service networks to reach disadvantaged (SES) and outer regional and remote populations
**New CDM interventions**

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<tbody>
<tr>
<td>Primary Prevention</td>
<td>Lifestyle risk factors</td>
<td>Lifestyle and disease risk factors</td>
<td>Disease Management and Tertiary Prevention</td>
<td>Disease Management and Tertiary Prevention</td>
</tr>
<tr>
<td>Secondary Prevention/ Early Detection</td>
<td>Disease Management and Tertiary Prevention</td>
<td>Disease Management and Tertiary Prevention</td>
<td>Continuing care</td>
<td></td>
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**Connecting Care program**

- **Get Healthy**
- **Private Insurer**
- **Self Management Support**
- **Care Coordination**
- **Case Management**
- **Aged and Community Care**

- Lifestyle risk factor management
- Lifestyle and disease risk factor management
One Deadly Step

- **One Deadly Step** project is a model based loosely on the men’s health initiative, “Pit Stop”, which related mechanical tune-ups to checking health.

- **One Deadly Step** project provides an ideal platform on which to establish committed engagement and improve partnerships with local service providers within health and social networks to improve health outcomes for Aboriginal people.
Working towards…

**Connecting Care program**

**Level 1**
People with chronic diseases and complex needs who frequently use hospitals and meet the HARP eligibility screen

**Level 2**
People with chronic diseases and complex needs who use hospital or are at risk of hospitalisation and meet the HARP screen

**Level 3**
People with chronic diseases and/or complex needs who can be managed in the community
  - Early Intervention in Chronic Disease (EiCD)
  - Diabetes Self-Management (DSM)

**Level 4**
Whole-population health promotion services
  - ‘Go for your life’ program

**HARP**
Intensive care coordination
  - Care across the continuum
  - Tertiary and secondary prevention
  - Enrolled patient population
  - Comprehensive assessment and care planning
  - Specialist medical and GP management
  - 24-hour advice
  - Additional services where appropriate
  - Self-management approach
  - Comprehensive hospital discharge planning

**EliCD**
Usual care
  - GP care
  - Self-management programs
  - Access to mainstream community services
  - Generic telephone advice

**Go for Your Life!**
Primary prevention
  For example: obesity reduction, smoking cessation, health promotion
Connecting Care program

Program elements

1. Targeted enrolment
2. Comprehensive assessment
3. Shared care planning
4. Continuum of care coordination
5. Continuum of self management support
6. Scheduled monitoring and review
7. Underpinned by shared decision making
Connecting Care program

Enablers

• Shared governance
• Workforce development
• Information Technology
• Contact Centre infrastructure
• Funding
• Evaluation
Based on HealthOne NSW model

- Integrated care provided by general practice and community health services
- Organised multidisciplinary team care
- Care across a spectrum of needs from prevention to continuing care
- Client and community involvement
• **Integrated primary health care** – in HealthOne NSW model there is shared governance with General Practice; mirrored in Connecting Care program

• **Population-based planning** – Connecting Care program is for sub-group of the population – those with complex care and support needs related to chronic disease – not whole population
Incentives for General Practice

- Partnership in administering and managing comprehensive “whole of life” Chronic Disease Management system
- Real time (electronic) alerts re admissions
- Support and assistance in navigating acute care system on patient’s behalf
- Access to free coaching services that support GP Management Plan/Team Care Arrangement
- Supplementary care coordination services as required or necessitated by disease trajectory
- Resource support to enable business practice change, if required
- GP name on hospital bed board – recognised partner in care
Incentives for Specialists

- Partnership in administering and managing comprehensive “whole of life” Chronic Disease Management system
- Effective communication with, and between, primary health care sector if patient’s condition deteriorating
- Support and assistance in navigating primary health care system on patient’s behalf
- Contribute to the development of community/primary health care based self management support services (including rehabilitation or maintenance)
- Supplementary care coordination services as required or necessitated by disease trajectory
- Resource support to enable business practice change if required
Program principles

• Integrated primary health care with specialist input
• Shared governance with General Practice (lead roles related to disease trajectory)
• Inter-disciplinary team – links all services
• Public health system will add value to General Practice interactions
• Contact Centre is essential for coordination and communication (inbound and outbound)
• Motivational interviewing is an essential workforce skill
Integrated approach with other NSW Health initiatives

- NSW Care Coordination Policy Directive
- GP / Hospital Clinical Handover project
- Integrated Services Framework for Specialist Health Care for Older People
- End of Life Decisions Policy Review
- HealthOne NSW
Integrated approach with other care coordination initiatives

- DVA Coordinated Veterans’ Care Program
- Closing the Cap – Indigenous Chronic Disease Package: Care Coordination and Supplementary Services Program