
**South Island
Shared Service Agency Limited**

*Supporting the South Island District Health Boards
E tautoko ana ngā Pōari Hauora ki Te Waipounamu*

**Summary of National, Regional and South Island
District Health Board Chronic Conditions
Management Activity**

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List of Abbreviations

ABC	Alleviating the burden of chronic conditions
CCM	Chronic Conditions Management
CVD	Cardiovascular disease
CORD	Chronic Obstructive Respiratory Disease
DAP	District Annual Plan
DHB	District Health Board
DHBRF	District Health Board Research Fund
DHBNZ	District Health Board New Zealand
HEHA	Healthy eating, Healthy action
HIS-NZ	Health Information Strategy for New Zealand
HISAC	Health Information Strategy Action Committee
HIV/AIDS	Human Immunodeficiency Virus/ Acquired immune deficiency syndrome
HRC	Health Research Council
LTC	Long Term Conditions
LTSF	Long Term Systems Framework
MoH	Ministry of Health
NHC	National Health Committee
NZDEP	New Zealand scale of Deprivation Index
PHCS	Primary Health Care Strategy
PHO	Primary Health Organisation
QIP	Quality Improvement Plan
SSA	Shared Service Agency
SIPFN	South Island Planning and Funding Network
SISSAL	South Island Shared Service Agency Limited

Executive Summary

There are a number of Chronic Conditions Management (CCM) initiatives being conducted in New Zealand at a national, regional and local level. This document provides an overview of these programmes and their progress at both a national and regional level.

The programmes and national projects discussed in this paper were identified through national policy initiatives, discussion with other Shared Support Agencies (SSA), Ministry of Health (MoH), District Health Board New Zealand (DHBNZ) and District Health Board (DHB) Chronic Care Project Managers.

With the recent emergence of a number of national projects relating to Chronic Conditions Management (CCM), South Island Shared Service Agency Limited (SISSAL) identified the need to summarise these and to enable a greater understanding of how national projects currently in progress.

Feedback from DHBs and the wider health sector indicates collaboration and communication between the national and regional programmes appear to be ad-hoc, which impedes the linkages in understanding and collaboration of CCM.

1 Introduction

Chronic Conditions in New Zealand are the leading cause of preventable morbidity, mortality, and unequal health outcomes and account for more than eighty percent of deaths, with the prevalence of chronic conditions continuing to increase exponentially, as a result of lifestyle factors, deprivation/education and the aging population (Wahl 2005). By 2020, it is estimated there will be an additional 24% increase of people with CVD and diabetes in the South Island (Carswell 2008), Wahl 2005).

Definitions

Chronic conditions are described as health problems that require ongoing management over a period of years or decades which affect the social, psychological and economic dimension of a person's life (World Health Organisation 2005, National Health Committee 2007, Ministry of Health 2004). They include diabetes, cardiovascular disease (CVD), asthma, chronic obstructive pulmonary disease, cancer, HIV/AIDS, depression and physical disabilities.

Ministry of Health

Chronic conditions management is one of seven specific priorities the MOH has for 2008/2009. The MoH specific focus is on 'getting ahead of chronic conditions' by maintaining the pace of the programme implementation Reducing the incidence and impact of CVD and Diabetes are two of the main population health objectives described in the NZ Health and Disability Strategy, Primary Health Care Strategy and Maori Health Strategy.

Methodology

The programmes and national projects discussed in this paper were identified through national policy initiatives, discussion with other Shared Support Agencies (SSA), Ministry of Health (MoH), District Health Board New Zealand (DHBNZ) and District Health Board (DHB) Chronic Care Project Managers.

National representatives from Chronic Conditions programmes were contacted to provide a summary of their activity; this included the programmes objectives and current activity.

The North Island SSAs were contacted to provide information about any CCM activity being completed across their region. South Island DHBs provided SISSAL with copies of their CCM framework.

2 National Activity

There are six chronic conditions programmes/projects being developed nationally, these are:

1. Long term conditions. programme (MoH)
2. Cardiovascular/diabetes quality improvement plan (DHBNZ/MoH)
3. Alleviating the burden of chronic conditions project.(DHBRF/ University Of Auckland)
4. PHO performance programme. (DHBNZ)
5. Long term systems framework (LTSF) programme.(MoH)
6. Chronic care and disease management of the health information strategy for New Zealand.(HISAC)
7. Postgraduate Certificate in Long Term Conditions Management (MoH)

2.1.1 Long Term Conditions Programme

- The long term conditions programme aims to develop a framework to provide an overarching vision and set of objectives that all existing programmes can work towards. The Framework does not replace existing national level projects. It will describe how existing projects are contributing to achieving the overall vision and will illustrate how current projects fit together to form a coherent programme of work around long-term conditions.
- This MoH programme will set priorities for the next five to ten years.

2.1.2 The Cardiovascular/Diabetes Quality Improvement Plan

- This programme will provide the health sector with a three-year plan to implement the priorities that are nationally agreed and co-ordinated in order to improve health outcomes and the quality of care for people with cardiovascular disease and/or diabetes.
- This is a joint DHBNZ and MoH national project on the CVD and Diabetes Quality Improvement Plan (QIP). As part of this project, a national steering group (see Appendix) has been developed that will meet regularly to progress the implementation of the Quality Improvement Plan. Their role is to ensure that DHBs are aware of the Quality Improvement Plan and to identify what recommendations District Health Boards (DHBs) are able to implement and when. It is also to help identify (where possible) gaps and help prioritise the recommendations.

2.1.3 Alleviating the Burden of Chronic Conditions (ABC) Project

- This District Health Board Research Fund (DHBRF) project has been commissioned to design research that addresses key knowledge gaps for the 21 DHBs and supports and promotes the translation of research into clinical practice. The key outcome for the project is to produce/develop a workbook that will guide District Health Boards to key interventions for improving care for people with respiratory and cardiovascular disease.
- The ABC survey was sent to the 21 DHBs requesting information on their CCM preparedness.
- The results of their survey to capture DHBs intentions to implement the QIP recommendations will be published later this year.
- This project is managed by the University of Auckland.

2.1.4 The Long Term Systems Framework (LTSF) Programme

- The goals of the LTSF are to support the implementation of the New Zealand Health Strategy, enhance sector sustainability and enhance system performance. The LTSF will comprise a framework of structures, processes and tools focused on strengthening sector co-operation and collaboration in relation to service planning, decision-making and delivery. This framework support any long term conditions initiatives.
- Six initiatives have been recently identified “to get started” and were considered in a Cabinet paper earlier this year.
- These actions are:
 - a. Sustainable service assessment.
 - b. Comprehensive long term service planning.
 - c. Service planning tools.
 - d. Health networks.
 - e. Prioritisation and decision making.
 - f. Health Futures.
- This programme is being managed by MoH and has DHB collaboration.

2.1.5 Action Zone 7 - Chronic Care and Disease Management of the Health Information Strategy for New Zealand 2005 (HIS-NZ)

- Health Information Strategy Action Committee (HISAC) sees Chronic Care and Disease Management being delivered through a combination of standards, improved access to information that supports quality improvement activities and the deployment of shared relevant patient information. The focus will be on interoperability between the primary and secondary sectors, especially in the management of cardiovascular disease (CVD) and diabetes.

2.1.6 PHO Performance Programme

- The PHO Performance Programme has been designed by primary care representatives, DHBs and the Ministry of Health to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs. Improvements in performance against a range of nationally consistent indicators will result in incentive payments to PHOs.
- The programme added a Cardiovascular/Diabetes capability assessment indicator as a one off task to indicate PHO capability to capture, measure and report CVD/Diabetes information this year. The programme has proposed a number of CVD/Diabetes indicators to be introduced to the programme once they have been endorsed by the programme’s governance group.
- This programme is managed by DHBNZ.

2.1.7 Postgraduate Certificate in Long Term Conditions Management (for nursing staff)

This is a pilot programme funded by the MoH via the Clinical Training Agency (CTA). The Postgraduate Certificate in Long Term Conditions Management programme commenced in February 2008 to support the Primary Health Care Strategy.

The purpose of the programme is to emphasise understanding and conceptual aspects of long term condition management including the pathophysiology of chronic disease with application in practice.

The pilot programme aims for the nurse:

- to increase understanding of a population in order to plan and implement culturally appropriate programmes of health care for populations and individuals with long term conditions, including helping individuals and populations to reduce their risk of developing chronic illness.
- to increase knowledge of long term conditions enabling the nurse to deliver client-centred health care in the community with a particular focus on lifestyle interventions and promotion of client self-care.

It is currently offered through the Universities of Auckland, Massey, Victoria and Otago. At the time of writing this paper, approximately 150 people nationally have commenced the post graduate programme.

2.1.8 Issues

Feedback from the DHBs and the wider health sector indicates collaboration and communication between the national and regional programmes appears ad-hoc, which leads to limited understanding and collaboration of the linking of CCM.

Examples:

- The ABC and CVD diabetes QIP programmes, both sent out questionnaires to DHBs at the same time requesting similar information and responses.
- Participation from the sector has led to limited feedback from the programmes.

3 Regional Activity

3.1.1 South Island DHB Chronic Conditions Project Manager's Teleconference

SISSAL conducts bi monthly teleconferences with the South Island DHB Chronic Conditions Project Managers. The purpose is to:

- Update progress on the chronic conditions frameworks/plans/implementation for each DHB.
- Discuss ways of sharing and learning from each other's work.
- Provide a forum for updates from the project managers from the ABC project, LTC Framework, MoH and CVD diabetes QIP.

3.1.2 South Island Diabetes Database

SISSAL in collaboration with Nelson Marlborough DHB (NMDHB) and Nelson Bays PHO is in the initial stages of implementing a project with the aim of establishing a regional approach to produce an information technology enhancement for the collection of data to improve healthcare and outcomes for diabetes and CVD with NMDHB. This is a pilot for a South Island initiative.

3.1.3 Central Region Technical Advisory Services (TAS)

Central Region Technical Advisory Services regional initiative on chronic conditions is currently on hold, although it features in their Service Level Agreement with each DHB in their region. They intend to commence work on this in early 2009. They have indicated they are keen to collaborate and share any information to progress regional initiatives with SISSAL.

3.1.4 Northern District Shared Agency (NDSA)

In December 2004 a report was compiled for NDSA that provided a descriptive review of chronic disease management and prevention in the northern region. The report also contained recommendations for improved regional collaboration and performance.

The report identified four action areas:

- Chronic disease workforce development.
- Strategic planning and collaborative learning.
- Information solutions.
- Evolution of funding frameworks (including Care Plus).

A meeting was held in 2005 between the four northern DHBs which resulted in no immediate direction forward. The region hopes to restart cross DHB conversations regarding chronic conditions, as it is felt that the DHBs now have more in common regarding their approach/philosophy.

3.1.5 Midland Region

The midland region does not have a specific CCM regional plan, however the appointment of the regional service plan co-ordinator has provided scope for the implementation of addressing chronic conditions management across the five DHBs.

To date a regional chronic conditions advisory group has been established regionally to provide greater service area coverage across a number of service areas including cardiac, renal and diabetes. Additionally the advisory group will provide a governance support role to the Information and Technology CC framework, a joint venture between Capital Coast and Taranaki DHBs.

4 Local (South Island) Activity

4.1.1 Summary of South Island DHB Activity

South Island DHBs have all signalled in their DHB District Annual Plans specific objectives to improve the management of the burden of chronic conditions in their populations. Five of the six South Island DHBs have formally implemented a specific chronic conditions management framework under which services can be provided and evaluated.

4.1.2 Links to South Island DHB's

Canterbury DHB	www.cdhb.govt.nz
Nelson Marlborough DHB	www.nmdhb.govt.nz
Otago DHB	www.otagodhb.govt.nz
South Canterbury DHB	www.scdhb.co.nz
Southland DHB	www.sdhb.govt.nz
West Coast DHB	www.westcoastdhb.org.nz

5 Conclusion

There appears to be significant consistency between South Island DHBs as provided in the regional District Annual Plan (DAP), strategic plans and at regional chronic conditions teams.

There are a number of national policies and directives which overarch CCM strategies and initiatives; these include the Health of Older People Strategy and Primary Health Care Strategy. PHO's are involved in a range of CCM initiatives including the PHO performance programme and careplus initiatives. SI DHB's CC strategies have incorporated the key recommendations from the National Health Committee's "Meeting the Needs of People with Chronic Conditions" strategic document.

The recent emergence of a number of national projects relating to Chronic Conditions Management (CCM), has highlighted the need for greater collaboration and communication between the national and regional programmes, which at present seem to be ad-hoc, and is impeding linkages in understanding and collaboration of CCM.

Appendix 1 (National Programmes)

National Programmes

Long Term Conditions Programme

The Long-Term Conditions Programme was established in mid-2007 in response to the National Health Committee Report, Meeting the Needs of People with Chronic Conditions. The team has a dual purpose:

- Galvanising action for long-term conditions in the health sector and inter-sectorally.
- Creating a sustainable process for Ministry of Health working on long-term conditions.

The Long-Term Conditions programme has an initial two-year lifespan. They have been established to create the environment and structures needed to embed a long-term conditions approach sustainably in the health and related sectors.

Their work covers the following key areas:

- Understanding the burden of long-term conditions.
- Unpicking the system blockages and barriers that are preventing a long-term conditions approach being sustainable, embedded in the health and related systems.
- Developing a framework and plan for addressing the system blockages/barriers.
- Building partnerships with key stakeholders.
- Supporting existing projects that are already contributing to our goals, to ensure that these are progressed in a co-ordinated way.

The Framework

The Framework does not replace existing national level projects. The Framework will provide an overarching vision and set of objectives that all existing programmes can work towards. It will also describe how existing projects are contributing to achieving the overall vision. In this way the Framework will illustrate how current projects fit together to form a coherent programme of work around long-term conditions. The programme will leverage off this work in setting priorities for the next five to ten years.

Key milestones from existing work will also form the basis for the system improvement plan.

The primary foci for long-term conditions management are promoting self-care, co-ordinated care, and integrated care. The most critical part to keep in mind is that the team is primarily interested in how they can use the following to enable a whole-of-system shift to these features of long-term conditions management across the board:

- Leadership.
- Policy.
- Resourcing.
- Accountability.
- IT.

They are also interested in how the following can be used to improve quality of existing work:

- Workforce capacity and capability building.
- Partnerships.
- Performance Enhancement Programmes (e.g. continuous quality improvement).
- Knowledge diffusion (e.g. innovation, collaboration, sharing best practice etc - but not only telling each other about it, also getting past issues of intellectual property so that we can actually give whole ideas and programmes to each other).

The programme is also working 'across-Ministry' to pull together existing projects into a more co-ordinated approach to long-term conditions. Projects and programmes that fall under this banner include primary health care, cancer control, CVD/diabetes, HEHA, health of older people, Key Directions (IT), disability policy, Pacific Health, Maori Health, strategic funding, primary mental health care and others.

CVD/Diabetes Quality Improvement Plan

The Quality Improvement Plan (QIP) was jointly developed by the Ministry of Health, DHBs, clinical experts and consumers. It provides the health sector with a three-year plan to implement the priorities that are nationally agreed and co-ordinated in order to improve health outcomes and the quality of care for people with cardiovascular disease and/or diabetes.

The Ministry's Chief Clinical Advisor, Dr Sandy Dawson says the plan is an important step towards finalising a nationally accepted programme for dealing with these serious health problems.

The QIP will be reviewed at intervals to coincide with the annual planning cycles of the Ministry and DHBs. The Ministry will approve any updates after consultation with DHBs and the health sector.

The QIP will work alongside other strategies including the Healthy Eating, Healthy Action (HEHA) programme and PHO performance programme to provide a broad range of improvements in services for people with cardiovascular disease and diabetes.

Key points of the Quality Improvement Plan

The QIP is focussing on improving the quality of services for people with diabetes, heart disease and stroke. The plan will assist the health sector in determining priorities and ensuring the best use of available resources reducing inequality by promoting national consistency and collaboration between DHBs, the Ministry of Health, Non-Government Organisations and the health sector.

The plan provides recommendations for action to improve patient outcomes, which are based on new and existing data that gives a good picture of how well the sector is coping with these chronic conditions.

The Expert Advisory Group who wrote the Quality Improvement Plan is chaired by Professor Jim Mann (Professor of Human Nutrition University of Otago) - The Expert Advisory Group consulted is made up of expert clinicians, DHB management, Non-Government Organisations and consumer representatives.

DHBNZ developed a web based survey (utilizing Survey Monkey) to capture DHBs intentions to implement the QIP recommendations. This survey also included questions about regional work, IT databases and DHB plans. The results of the survey are due to be published later this year.

Alleviating the Burden of Chronic Conditions (ABC) Project

The ABC project (February 2007) is the first project to be funded through the District Health Board Research Fund (DHBRF). This fund is in partnership between the 21 DHBs and the Health Research Council (HRC) designed to commission research that addresses key knowledge gaps for DHBs and supports and promotes the translation of research into clinical practice.

Current models of care for chronic conditions such as cardiovascular disease, diabetes and respiratory disorders have not been translated widely into practice. Professor Martin Connelly from the University of Auckland and his team are addressing this issue by gathering together both international and local knowledge in the area of chronic care management and putting it into an easily understood format.

The aim of this study is to review the New Zealand and international literature for effective interventions that improve outcomes and will reduce inequalities particularly for Maori and Pacific peoples. The study will also identify local initiatives by surveying all 21 District Health Boards. It will then evaluate a sample of initiatives to identify the critical components that are needed for achieving successful outcomes for people with chronic disease. Finally with the help of an expert advisory group, a workbook will be produced that will guide District Health Boards to key interventions for improving care for people with respiratory and cardiovascular disease.

The study will use Participatory Action Research whereby those using the workbook will help form its contents. The team has conducted workshops regionally and questionnaires with the DHBs. They have developed 11 dimensions by which they will measure DHB questionnaire responses. At the South Island (Christchurch) workshop in May 2008 the participants used the dimensions to measure the questionnaire responses from DHBs (anonymised), as an exercise.

PHO Performance Programme

The PHO Performance Programme has been designed by primary care representatives, DHBs and the Ministry of Health to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs. Improvements in performance against a range of nationally consistent indicators will result in incentive payments to PHOs.

The first performance period commenced 1 January 2006 with 29 PHOs participating. PHOs entered the programme at six monthly intervals, once they met the Programme prerequisites.

The first pre-requisite phase for the Primary Health Organisation (PHO) Performance Programme commenced in July 2005, with the first performance period having started 1 January 2006. A staged approach was developed so that PHOs can choose when to take up the opportunity to participate in the Programme.

On 1st July 2007, a Cardio Vascular Disease (CVD)/Diabetes capability indicator was added to the Programme's indicator set. This indicator is defined as:

- Ensuring all PHOs and their member practices have the necessary capability to consistently undertake high quality assessment, recording, management and reporting of CVD and Diabetes across their enrolled populations.

The target for this indicator is defined as:

- Confirmation by the local DHB that the PHO has submitted an Assessment that ensures PHO capability to capture measure and report CVD and Diabetes information in compliance with guideline standards.

This capability indicator was introduced to focus attention on the development of new people skills, clinical processes, systems and technology in readiness for the future implementation of CVD and Diabetes indicators.

Parameters:

Assessments must enable PHOs and their contracted providers to identify and acquire what additional capacity (if any), is required to assess and record, manage and report CVD/Diabetes risk across their enrolled populations.

PHOs must ensure that any additional capacity is in place by 30 June 2008 to ensure that they are capable of meeting future indicator requirements.

The programme has proposed a number of CVD/Diabetes indicators to be introduced to the programme once they have been endorsed by the programme's governance group.

Long-Term Systems Framework Programme

The Ministry of Health is leading the development of the Long Term Systems Framework (LTSF) in collaboration with key stakeholders across the health sector and other agencies. The goals of the LTSF are to support the implementation of the New Zealand Health Strategy, enhance sector sustainability and lift system performance. The LTSF will comprise a framework of structures, processes and tools focused on strengthening sector co-operation and collaboration in relation to service planning, decision-making and delivery.

There are a number of LTSF work streams, including visioning. The visioning work stream is focused on developing a clear long term direction for the health system. As part of the visioning work stream, DHB and other key health sector stakeholders across the country are participating in a series of 10 visioning workshops, facilitated by HP Consulting. The South Island workshop was conducted in May 2008.

Action Zone 7 - Chronic Care and Disease Management of the Health Information Strategy for New Zealand 2005 (HIS-NZ)

The Health Information Strategy Action Committee has developed a discussion document with the purpose of stimulating discussion and responses from the health and disability sector practitioners, providers and funders about the issues and opportunities associated with the improved usage of existing and emerging information technologies and information management systems in the health and disability sector.

The Document is an "Initial View" (2006) and focuses on the identification and management of patients and populations at high risk, or with chronic conditions. Information may also be generated to support preventative approaches to chronic conditions.

Improvement in the management of chronic disease will be achieved through improved information sharing with all providers including relevant NGOs. However, the focus will be on interoperability

between the primary and secondary sectors, especially in the management of cardiovascular disease (CVD) and diabetes.

HISAC sees Chronic Care and Disease Management being delivered through a combination of standards, improved access to information that supports quality improvement activities and the deployment of shared relevant patient information.

What is happening now:

Responsibility for implementing the Health Information Strategy for New Zealand lies with the whole health and disability sector under the leadership of HISAC. HISAC is working closely with sector representatives to prepare more detailed descriptions of the current problems and health practitioners' priorities for improvements.

Appendix 2 (National Health Committee Recommendations)

National Health Committee Recommendations

What is the NHC recommending?

The recommendations contained in this report fall into two broad areas: Part A addresses policy direction and outlines a comprehensive framework of areas for change, based on actions for equity. It includes planning for community collaboration. Part B focuses on service provision, presenting areas for health sector integration or alignment, as well as outlining care and coordination of people with chronic conditions within and across PHOs. This includes outcomes sought for information systems and workforce development to support change.

Develop District Health Board-based chronic conditions frameworks.

The NHC is recommending that each DHB develop and implement a chronic conditions framework that focuses action, integrates service provision and is population specific.

The framework outlines a full range of interventions, reflecting planning for whole systems change. A generic system of chronic care management is recommended, that includes clinical pathways and programmes for people diagnosed with specific chronic diseases. The framework aims to balance the development of local responses as well as achieve areas of national consistency. The key requirements sought are based on chronic care models and best practice evidence.

Reduce health inequalities.

Reducing inequalities is already a national priority. Leadership and commitment is required to remove barriers to achieving equalities of health at organisational and individual levels. The NHC believes these inequalities are resolvable and is asking that DHBs demonstrate how their approach to chronic conditions will reduce health inequalities within existing processes for accountability to the Ministry of Health.

The NHC believes that every health professional and organisation has a duty and responsibility to address racism and equity of access to health services. To support this, the NHC recommends the use of equity tools and monitoring processes by DHBs and PHOs to ensure equitable access to and through the system by populations with the highest demonstrated need.

The NHC recommends the Ministry of Health and DHBs work together to design accessible and culturally-appropriate services in collaboration with high-need populations. In addition, the NHC recommends the Ministry of Health resource the development of tools capable of evaluating the separate elements of culturally-appropriate services.

Plan community engagement.

The NHC seeks for community engagement to take place in a planned and sustainable way. Community-based and whole-of-government collaborations can create a healthy living environment, directly affect the wider determinants of health and improve services for people with chronic conditions. There is a need to encourage intersectoral collaboration by identifying shared concepts and goals, sharing information on a regular basis and clarifying roles and responsibilities, including resourcing and funding. The NHC endorses this being undertaken as part of planning processes that encompass the whole district.

Integrate structures and services.

The NHC is recommending the Ministry of Health work with DHBs to bring about comprehensive alignments within health and social sectors, between health providers and services and across health disciplines. It acknowledges that actions in this area will require extensive planning and implementation. However, there are considerable benefits to people with chronic conditions and some benefits to health providers in achieving integrated health systems.

Ministry of Health report to the Minister, December 2005

Integration and alignment of services rests on data, information and knowledge. It is critical to have consistent data collection, effective communication systems, and sound processes to build knowledge. The NHC looks for outcomes congruent with chronic care models and outlines specific areas of interest.

Provide a central contact person in each District Health Board.

The NHC recommends that each DHB nominate a person within their current workforce structure as a contact point for problems that arise for people with chronic conditions when they have difficulty accessing health services due to lack of alignment or integration. It expects feedback from this person to contribute to prioritising areas for alignment or integration within chronic conditions frameworks.

Provide effective chronic care management and coordination.

The NHC wishes to strengthen the following areas in PHOs that are evidenced to be beneficial to people with chronic conditions:

- proactive primary care: population health approaches to prevention, monitoring, and intervention.
- self-management: information, skills and referrals to support the person and their family/whānau to manage their condition.
- coordinated care: comprehensive assessment, detailed care planning, intensive support and management, and coordination of services.

To deliver these elements consistently and with accountability, the NHC is recommending that a care and coordination model is implemented. It asks that this proposed model is supported by national guidelines, and a nationally-consistent assessment and referral processes.

The need for consistent assessment and treatment of depression and pain, as well as improvements in referrals to rehabilitation and palliative care, are highlighted.

Provide a chronic care coordinator at the primary health organisation level.

The NHC seeks the provision of effective coordinated care for people with chronic conditions experiencing short-term acute health/life crises or ongoing complexity of health conditions and life circumstances. It is recommending these people be allocated a care coordinator. This is strongly supported by international chronic care models as part of achieving quality care and patient safety.

Undertake workforce development.

Broad workforce development recommendations include the increase of Maori and Pacific peoples in the health care workforce, as well further education and training for all health professionals. Specific recommendations include the need for resourcing and developing capability in self-management, pain management and cognitive-behavioural therapy.

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