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Chronic Care

NSW Chronic Disease Management Program

Readmissions Master Class
14th November 2013

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CDMP Overview

- Aims to support people with chronic disease to better manage their condition in order to improve their health and quality of life, prevent complications, and reduce PPHs.
  - Deliver coordinated, person-centred care for clients across multiple providers and settings.
  - Enhance care provided by the patient centred medical home by integrating it with community health and acute hospital services.
  - Providing care coordination and self-management support.

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CDMP Models

- Models implemented across the state vary according to local needs and resources. Variation exists in several key areas inc:
  - Provision of self management support (telephone based, internal /external provider)
  - Role and location of care coordinators (LHD or ML or both)
  - Level of engagement with primary health care providers and specialist services

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CDMP Service Model

Principles

Person-centred care
Address health inequities
Enable primary health care
Evidence-based care
Local partnership approach

Targeted Enrolment
- Identification (hospital, GP, other referral)
- Consent
- Risk stratification

Comprehensive Assessment

Shared Care Planning

Service Delivery
- Care coordination
- Self management support

Monitoring and Review

Resources

Governance
Workforce
Systems/ IT
Reporting
Evaluation

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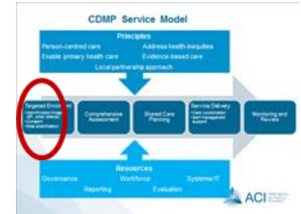
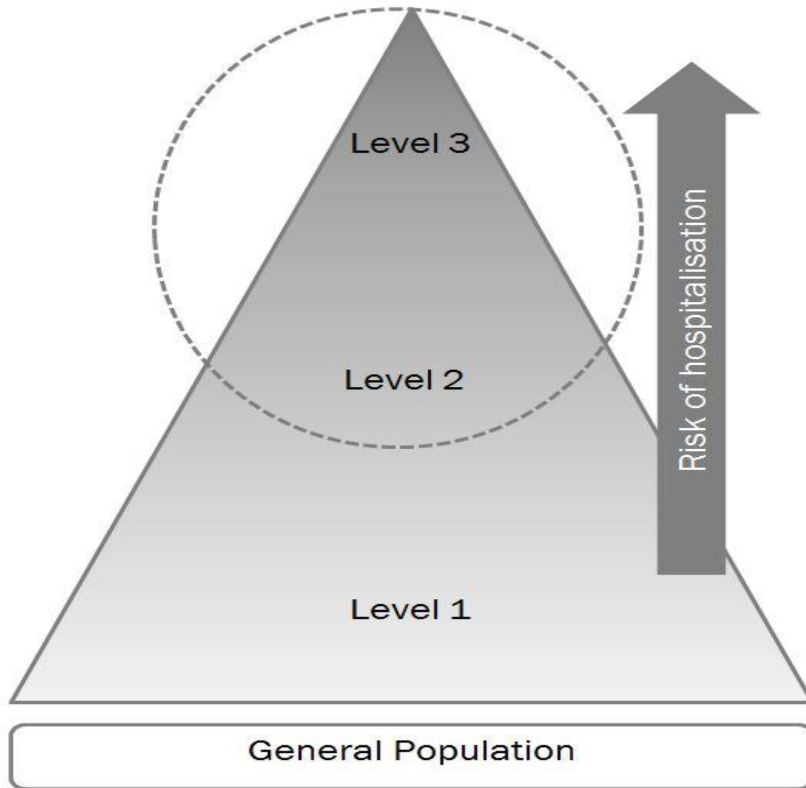
CDMP Target Population





Level 3: People with complex, unstable and often comorbid conditions who are at very high risk of hospitalisation and require intensive care coordination.

Level 2: People at high risk of hospitalisation who need help managing their disease through care coordination and self-management support such as health coaching.

Level 1: 70-80% of people with chronic disease who are in control of their condition and able to self manage with limited support.

Health promotion and primary prevention

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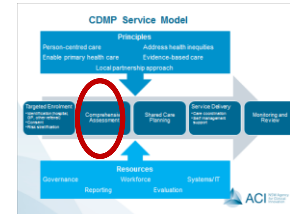
Comprehensive assessment



- Allows for a better understanding of the person’s needs and circumstances to inform care planning.
- CDMP draws together the results of previous assessments into one complete source of information about the client and makes it available to GP and other health professionals.

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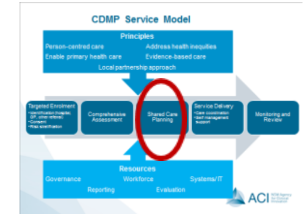
Shared care plan



- Individualised management plan.
- Ensures that everyone including the patient and carer are informing the care plan and working towards achieving the same, agreed goals.
- Supported by GPMP and TCA MBS items.
- Contact centre or ARGUS can facilitate “sharing”.

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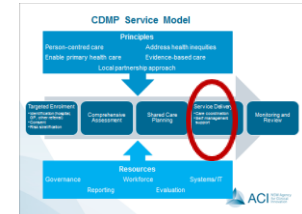
Care coordination



"The delivery of services by different providers which occurs in a coherent, logical and timely manner, consistent with the person's medical needs and personal context"

- Coordinating implementation of the care plan
- Led by the 'medical home'
- Involves the effective exchange of information between care providers

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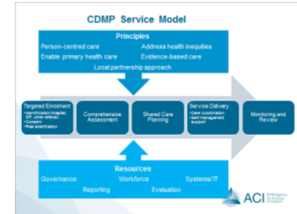
Self-management support



- Helps people feel more confident managing their condition and supports them to work towards their health care goals.
- Approaches include health coaching (by telephone or in person) and individual/ group education programs
- CDMP primarily supports in-house or outsourced telephone-based health coaching

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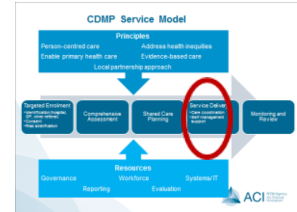
CDMP age profile 2013



Percent

50
45
40
35
30
25
20
15
10
5
0

< 50
51 - 64
65 - 75
> 75

Age in years

■ CDMP participants
■ NSW comparison cohort

< 50	9.6	10.1
51 - 64	21.5	22.4
65 - 75	27	23.9
> 75	41.8	43.5

GI Feb2013

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Readmission Rates 2009/10

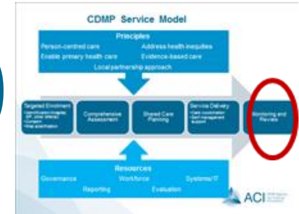

Figure 12: Unplanned readmissions for CHF within 28 days of discharge, standardised rates, large NSW public hospitals, by geographical area, 2009–10

Principal referral (A1) Major metropolitan (B1M) Major non-metropolitan (B1NM)

High volume: >400 hospitalisations Medium volume: 201–400 hospitalisations Low volume: <200 hospitalisations

Unplanned CHF readmissions per 100 discharges

16
14
12
10
8
6
4
2
0

Auburn
Canterbury
Campbelltown
Wollongong
Blacktown
Fairfield
Coffs Harbour†
Wagga Wagga
Orange
Royal Prince Alfred
Prince of Wales
Westmead
Liverpool
Wyong
Calvary Mater
NSW rate
Mona Vale
Royal North Shore
Concord
Sutherland
Tamworth†
Hornsby and Ku-Ring-Gai
St George
Nepean
Bankstown
St Vincent's
Manning†
Gosford
John Hunter
Manly†
Shoalhaven†
Maitland†

Urban LHDs

Central Coast & Northern Sydney
Illawarra Shoalhaven, South Eastern Sydney & St Vincent's
Nepean Blue Mountains & Western Sydney
Sydney & South Western Sydney

Rural LHDs

Far West & Western NSW
Hunter New England
Mid North Coast & Northern NSW
Murrumbidgee & Southern NSW

Section two:

CHRONIC DISEASE CARE: Another piece of the picture, COPD and CHF July 2009 to June 2010 www.bhi.nsw.gov.au

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Readmissions –CDMP

- Integrated approach
  - Whole of system – positioning of the program
  - Aboriginal Health
  - Aged Care
  - Mental Health
  - Transition

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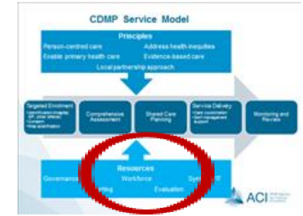
Readmissions –CDMP



- Clinical systems
  - Flags
  - Real time reporting
  - EDRS
  - Risk Stratification

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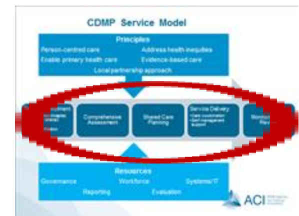
Readmissions- CDMP



- Service Delivery Models
  - Rehabilitation programs – self management
  - Patient Action plans – shared visibility
  - Health Coaching- disease specific, lifestyle, health literacy, health support
  - Discharge/Presentation follow up
  - Contact centres– care navigation, recall, surveillance,

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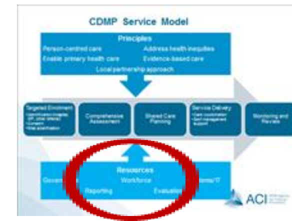
Readmissions- CDMP



- Workforce
  - Training education – cross sectors
    - Health coaching, online self management,
  - Chronic disease management
  - Advanced Care Planning

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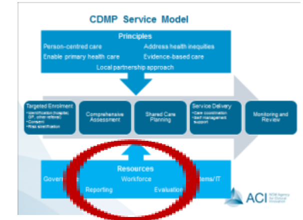
CDMP Evaluation



- In progress by external consortium led by The George Institute for Global Health
  - 4 streams: health service utilisation, patient/ carer experience, program models, pilot
- Due for completion Sept 2014
- LHDs have also collected information
  - Early data indicates clients have reduced hospital admissions and length of stay

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