

**Plan for**

**Chronic Care  
Management**

**in Counties Manukau**

**2001-6**

**Prepared for the Counties Manukau District Health Board**

**September 2001**

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## Introduction

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“Ma pango, ma whero, ka oti te mahi”

The 5% of our population who have chronic conditions have more ill-health, have more contact with the system and consequently incur higher health care costs. This represents manageable risk for the DHB. Costs can be reduced through a more integrated health system, with improved access designed around the needs of the consumer, with the added benefit of improvement in patient quality of life.

The focus of this plan is the patient/whanau relationship with mainstream general practice teams and the link to specialist advice and further clinical services. Thirty five percent of our population is Maori and Pacific people. The burden of chronic disease is even greater in this group. To provide effective care to Maori and Pacific people will require that health providers are equipped with the knowledge and skills of culturally competent care in addition to new clinical skills and support systems. The responsibility to provide culturally competent service is a requirement of the Treaty of Waitangi, and an imperative for any organisation focused on quality.

The proposed programme is one of **Chronic Care Management** (CCM). This is a proven approach for people with specific progressive conditions, ones where progression can be significantly reduced by straightforward and usually inexpensive interventions. Modifiable conditions include diabetes, unstable angina, ischemic heart disease, chronic congestive heart disease and COPD or “smokers lung”, and asthma. Frail Elderly, depression and other groupings may also benefit from the approach.

CCM involves regular maintenance reviews, and carefully selected approaches based on evidence of best practice. New approaches to bringing specialist skills and advice to each individual in the community setting are required. Ultimate success is dependant on the individual, and their own support group, assuming responsibility for their own condition whilst working with the medical profession as a supporter of this process. Several pilot projects in Counties Manukau have ensured that this can be done in our region.

**The combination of these benefits, with attendant reduced overall costs, will contribute to Counties Manukau people receiving significantly better value for their health expenditure.**

The need for such approaches was highlighted in the New Zealand Health Strategy released in December 2000. It outlines 12 goals. 5 of these are relevant to this work:

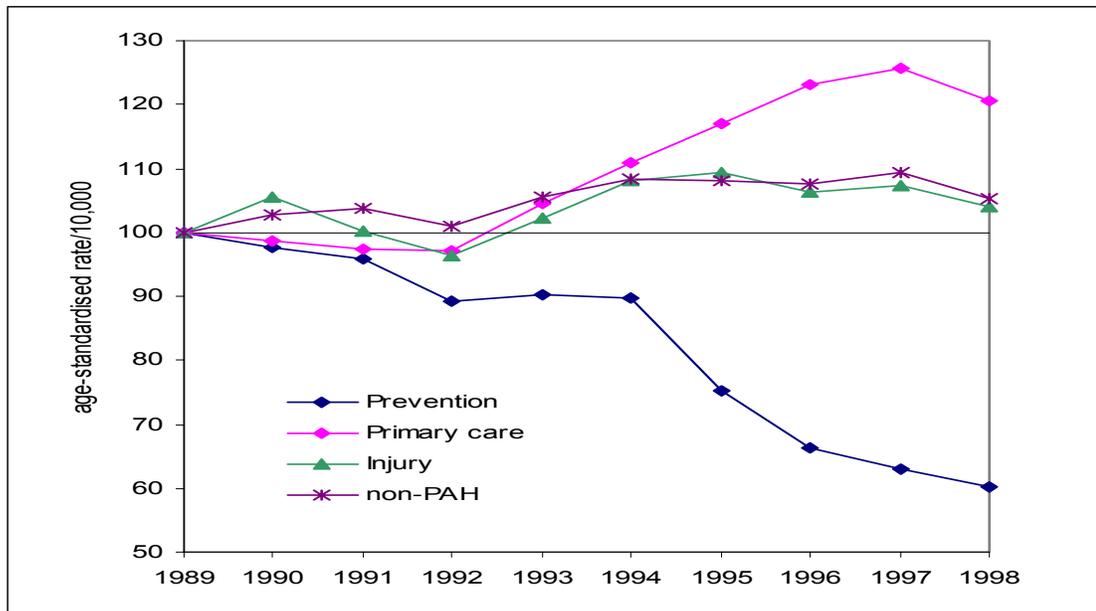
- reducing smoking
- improving nutrition
- increasing the level of physical activity
- reducing the incidence and impact of cardiovascular disease
- reducing the incidence and impact of diabetes

All of these are implicit components of the proposed programme.

In February 2001, the Minister released the Primary Health Care Strategy. This offers a vision, to be achieved over the next 5 – 10 years. *“People will be part of local primary health care services that improve their ongoing health, keep them well, are easy to get to and coordinate their ongoing care. Primary health services will focus on better health for a population and actively work to reduce inequalities between different groups.”*

The strategy suggests a process to achieve this, a process which is the foundation of CCM. It emphasises the need to shift from focusing on individuals to looking at the health of the population, to develop care systems, which are community and people focused, and recognises that education and prevention are equally as important as treatment. Finally it makes the point that this be provided by a clinical team, which includes nursing and community outreach. These are all basic principles of chronic care management.

The significance of not modifying current processes can be seen in the following graph. This shows the relative trends in categories of hospitalisations in New Zealand from 1989 – 1998. Admissions that “might be avoided through different interventions in primary health care” are on a steady rise.



Prevention	=	Potentially preventable hospitalisations
Primary Care	=	“ambulatory sensitive admissions” or admissions that might be avoided through different interventions in primary health care
Injury	=	admissions which are potentially avoidable avoidable through injury prevention
Non PAH	=	unavoidable admissions

Counties Manukau has a profile with even higher health needs than almost anywhere else in New Zealand. This profile was described in May 2001 by Gary Jackson (*Jackson G, Palmer C, Lindsay A, Peace J. Counties Manukau Health Profile. CMDHB, May 2001*). The most significant findings for adults are that:

For virtually every health condition, Maori and Pacific people have higher rates of disease, and poor people do worse than wealthy. Counties Manukau has 18% Maori and 17% Pacific people in its population. . 34% of the total population live in areas that can be classified as “very deprived” (deciles 9 and 10), as do 45% of children, as measured by the New Zealand Deprivation Index 1996.

Excess premature mortality in Counties Manukau 45-64 year olds compared with all New Zealand is already apparent. Life expectancy at birth in Counties Manukau is 1.2 years shorter than the New Zealand average. The over 65's will increase from 35,000 currently to 73,000 by 2021. Diabetes, obesity, smoking and other health issues will contribute to added demands as this population ages, and the Counties Manukau population continues to grow at over 2% per year.

Hospitalisation rates have increased yearly since 1995 at a higher rate than for New Zealand as a whole at 8% per year. There were 36% more discharges in 1999 than occurred in 1995 in Counties Manukau. Of all hospitalisations 34% would be considered potentially avoidable (38% Maori, 40% Pacific), as compared with 30% for New Zealand. Much of the scope for prevention of these would lie in the primary care sector.

There is a shortfall of the equivalent of 40 general practitioners-worth of primary care in Counties Manukau. Significant investment in primary care, a better system of primary care, and better integration of primary and secondary care is needed.

Smoking in Counties Manukau is a major issue and risk factor for several of the chronic disease. NZ stats in *Our Health Our Future 1999* show about 25% of Nzers are current smokers and 25% ex smokers. 47% Maori women, 40% Maori men and 35% Pacific men are smokers. Smoking rates rise in a straight line from decile 1 (12%) to decile 10 (29%) (most socio economically deprived).

The CCM programme in this plan uses approaches, which have been demonstrated to be effective in reversing such figures. It is also based on interventions already shown to be implementable in Primary Care in Counties Manukau. Its implementation will make a major contribution to returning our population to better health, in an economically sustainable manner.

## Summary

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### 1. Rationale for CCM

Patients with chronic diseases who require chronic care consume a considerable proportion of the health dollars. The number of ambulatory care sensitive admissions for chronic diseases has risen significantly over the last ten years. There is compelling evidence that providing more resources for their management in general practice will decrease secondary care costs, however some initial investment is required before these savings can be realised. This document proposes a programme, including an outline of an implementation plan, for the evolution of **chronic care management (CCM)** for targeted groups of patients in Counties Manukau, with the emphasis on care in the community.

### 2. The proposed programme

The programme is designed to implement a generic CCM programme for patients with one or all of specified targeted conditions, across primary and secondary care. It is based around the general practice team. This is on the grounds that this process is the most cost effective delivery system to:

- manage the patient in the context of their whanau/family and community
- ensure patients do not 'fall through the gaps'
- address all targeted patients' chronic health problems in an holistic way
- provide continuity of care over time
- create seamless care for the patient
- distribute tasks to make the most efficient and effective use of team member's skills
- provide extra resources for the hard to reach
- reduce duplication and waste

### 3. Key components

The key components which this proposal uses for a successful Chronic Care Management programme are:

- **targeting and tracking high risk patients for whom there is potential to reduce this risk**
- **organising interventions, which have been shown to be cost effective, into a system of care for the targeted population**
- **providing the support for the new processes and systems and the required cultural change in general practice**
- **implementation of processes and systems to create and support sustained change in patient behaviour**

#### 4. Volumes and costs

ROI remains under active development.

#### 5. Critical factors for success are considered to be:

- a commitment to funding
- a right person appointed to drive the programme
- early mandate from key stakeholders
- appropriate use of incentives and disincentives
- robust IT systems that support the process
- ongoing refinement and quality improvement

#### 6. Structure of this document

Section One outlines the **vision, mission and goals**.

Section Two describes **the components of the programme model** for chronic care management. It includes:

- targeting groups of patients according to need and cost effectiveness of interventions
- ensuring general practices have systems in place that support CCM
- ensuring providers have skills in behavioural change and patient education
- the way in which best practice clinical guidelines are converted into changed clinical practice
- the required support from and integration with secondary care
- requirements for evaluation, audit and feedback
- cultural competency requirements
- IT system requirements

Section Three outlines **implementation requirements for governance and management** at all levels, covering all groups involved.

Section Four an overview of the key **operational steps** required to implement the plan, starting with formation of the governance group and appointment of the CCM Manager, and then detailing the key tasks to be done in the first year. A more detailed plan should be developed by the project manager once funding is approved.

Important tasks over the next five years also include:

- Merging the funding for CCM with the new **capitation formula** and into general practice contracting requirements. As this happens it will be important to ensure that the effects of incentives and disincentives on engaging general practice teams to provide effective and efficient services, are monitored and addressed.

- Collecting information on patient outcomes and costs of CCM services to enable ongoing **refinement of patient target group selection** and continuous improvement of service delivery.

Section Five contains the **budget**. Calculation of savings, quantification of benefits and **ROI** of the proposed programme depend on the exact mix of patients included in the programme and whether projected savings from overseas programmes translate into savings in South Auckland. However estimates are made in this section.

## 7. Overview of implementation

### Current situation

81 GPs in 31 practices are currently involved in one or more chronic disease pilot projects, the majority with less than 10 patients.

### First year

- These practices will increase the number of patients they have enrolled in CCM to an average of 25 patients per GP. Each of these patients will be selected according to the target requirements for at least one of the current projects.
- The four current CCM projects will be streamlined so that they all follow the same generic CCM processes
- Each project will be rolled out to each of the involved practices in the new generic format.
- Alongside this assistance will be given to the practices to improve their structures and systems to provide CCM. The general practice team will provide the extra CCM services to each patient in a seamless way, addressing all of each patient's health problems for which there are CCM projects operating.

### Subsequent years

Each subsequent year the number of patients and number of practices will increase until after five years it is expected that around 22,600 patients, 300 doctors and 100 practices are involved, at the cost of \$356 per patient per year.

## 8. Recommendations

1. Counties Manukau DHB approve the plan in principle and make funding allocations to meet the budget
2. General Manager Integration Care coordinates the formation of the governance group (see Section 3.2).
3. Governance group is tasked with endorsing the policies within the document
4. Manager of CCM Steering Group (CCM Steering) is appointed (See section 3.3) and moves quickly to develop the implementation plan in Section 4 into a detailed operational plan with responsibilities and timelines.
5. Members of CCM Steering Group (see Section 3.3) are appointed.

6. Current Disease Management project leaders become Project Managers answerable to the CCM Steering Group (See Section 3.5) and commence work on aligning their projects with the generic model, while ensuring currently enrolled patients continue to receive disease management services beyond the pilots.

**The writing group for this plan were:**

Dr Jocelyn Tracey (Chair), Dr Peter Jansen, Sue McAuley, Dr Gary Sinclair and Dr John Wellingham with Professor Harry Rea and Dr Siro Fuata'i in close consultation.

The plan was widely distributed for consultation through all phases of its development and has received wide support and endorsement.

**The terms of reference for the writing group were:**

1. Overall Vision  
To maximise potential health outcome gain for people with chronic diseases in Counties Manukau DHB.
2. Goal  
To achieve alignment and integration of disease management programmes

Explanation:

Disease Management programmes improve management options to those of “best evidence”, reduce unnecessary variation and improve health outcomes (improved quality) whilst reducing fragmentation and duplication (reducing cost and further improving quality by improved consumer acceptability). This obtains best value.

3. Objectives
  - to commission a writing group, supported by a working party and reference group, and guided by a steering group,
  - to recommend to CM DHB, a plan to implement an appropriate model or models for integrating individual chronic disease management programmes, including funding options.
  - The plan will include 1 year and a 5 year outlooks, will be specific on deliverables over the first 12 months, and is to be available by mid June 2001

**The plan was commissioned from the writing group by Counties Manukau District Health Board Integration Unit on 3 May, 2001**

# **1. Vision, Mission and Objectives for Chronic Care Management**

## **Vision**

A generic system of chronic care management across community and hospital settings that maximises health care outcomes for targeted patients with chronic disease in an efficient manner.

## **Mission**

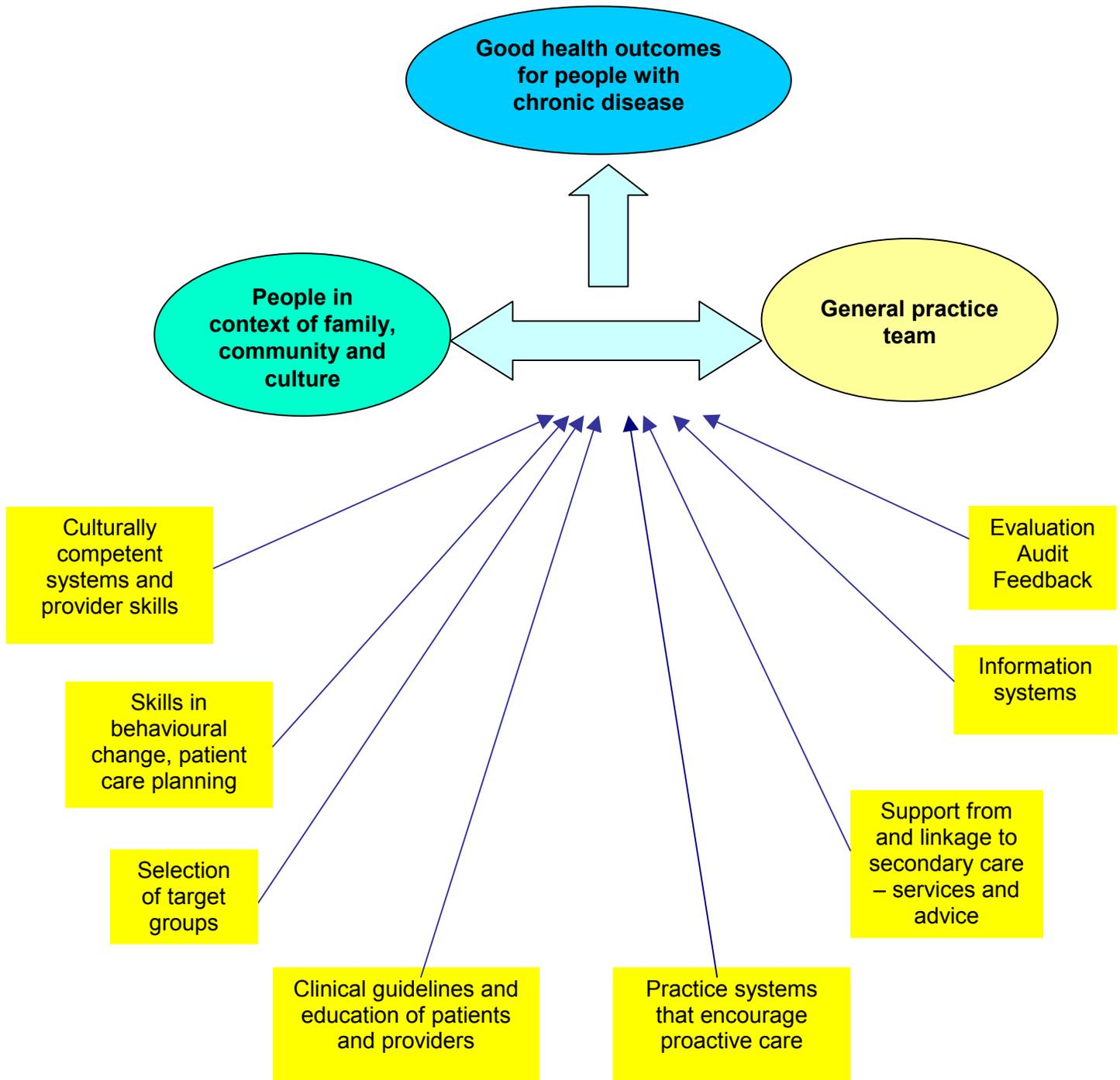
To support patients with significant health needs resulting from chronic diseases by providing chronic care management as a clear coordinated care process in partnership with the patient, their whanau/family and the wider community.

## **Goals**

- A generic approach to the management of chronic disease, built on the work already done in the four disease management projects in Counties Manukau (COPD, Diabetes, CHF, Asthma/COPD), and able to be expanded to include other patients, other providers and other diseases.
- Improvements in patient health indicators such as quality of life, morbidity, reduced need for hospital admissions, increased length of life, satisfaction with the services provided.
- Services designed to effectively meet the needs of specific patient groups who currently receive limited benefit from existing services
- Motivated providers who enthusiastically support the principles of chronic care management and patient/whanau empowerment.
- Health resources used in the most effective and efficient manner

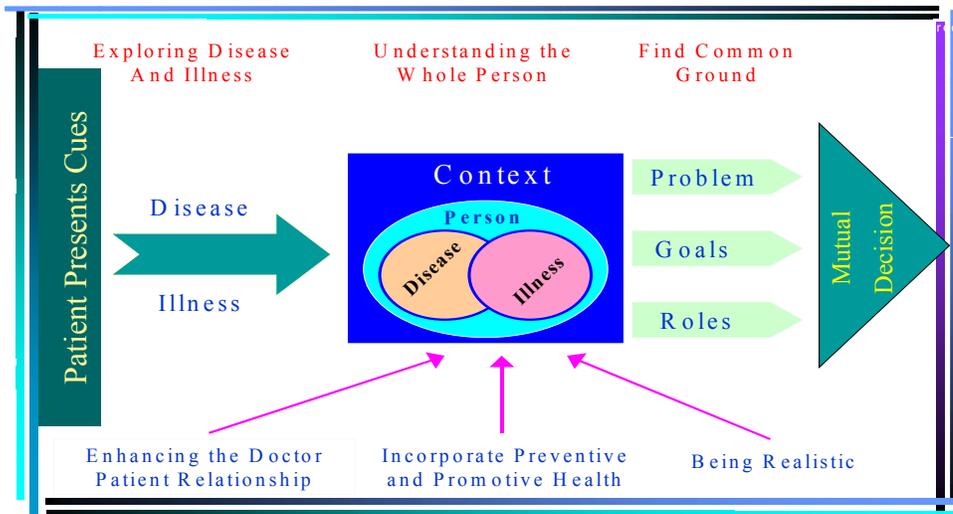
## 2. Model for Chronic Disease Management

The model from the Chronic Care Management Policy and Planning Guide for Counties Manukau (August 2000) has been adapted with modifications.



There is good evidence that for patients with chronic disease to have better health outcomes it is important that they feel understood, respected and empowered by the general practice team to share in clinical decisions about their management and make healthy lifestyle choices. The better the understanding of the patient in terms of their own self, their family, their community and their culture, the better the practice team will be able to assist the patient in this way.

The importance and complexity of the factors influencing the patient and the general practice team are further expanded in this model:



The principles and methods of the CCM model are expanded in the following sections.

## **2.1 Selection of target groups and initiatives for CCM**

The identification of target groups for a CCM programme is integral to consideration of value. CCM requires a change to the system of care and as such this requires assessment of the costs and benefits of such a change. In addition we need to take account of the investment by health care teams in education and skill development, new technologies, etc. Targeting these limited resources to areas of greatest need includes careful assessment of a target population – those patients who have most to gain from the programme or in whom a CCM can maintain health status while optimising the use of resources.

Financial analysis involves economic analysis of the proposed programme and any reasonable alternatives. This may include the status quo as a comparator. The aim is to determine the effectiveness of the activities of the CCM programme – that is, the results of this system in the real world.

### **Principles**

National priorities or regional priorities should be taken into account when selecting a disease area or target population.

Needs analysis, even if limited, guides prioritisation and selection of target groups.

A benefit analysis will show whether it is those with the most severe or the least severe disease who will benefit more from extra interventions (eg patients with risk factors for cardiovascular disease vs those who have already had a myocardial infarction).

Health gain and capacity to benefit should be considered alongside disease burden and costs of care.

Health economic analysis is important because we have limited resources and expanding needs that require decisions about allocation of these limited resources. To guide decisions about resources allocation a prior economic analysis is necessary if a change to practice and systems of care is contemplated.

CCM does not involve new methods of treatment, but rather consideration of the implementation of new systems of care. So the overall costs of the new system of care should not exceed the benefits.

The investment required is marginal cost to the patient, provider and funder. The investment includes both set up costs and ongoing intervention costs.

The best available data will be used for any analysis. Modeling may be used where data from realistic trials and/or RCTs can supplement other sources of information. Explicit statements about the assumptions, uncertainties and limitations of the model are to be included. In cases where uncertainty exists the inclusion of a sensitivity analysis is recommended.

Estimates of costs will be included as well as estimates of benefits. The differing costs and benefits of applying the intervention to patients with a varying level of disease burden will also be included in the analysis.

The goal of economic analysis is to optimise the use of health resources, not to minimise costs.

Chronic care management will require initial extra investment in general practice. Resultant savings realised within secondary care or marginal secondary savings realised should be used to expand the general practice disease management programme.

## **Methodology**

Suggestions for CCM will come from sources that include:

- primary and secondary care clinicians
- analyses of primary and secondary care morbidity and mortality data
- community advocacy groups
- general practice
- DHB
- Ministry of Education
- national and regional health goals

These suggestions will be prioritised and then referred for needs analysis and financial analysis. An in depth scoping process is of major importance in ensuring that new interventions are appropriate and health dollars spent wisely. Types of analysis will vary depending on the situation, proposed target group, and suggested intervention. The resulting recommendation will be expected to define the target population (e.g. disease, cluster of diseases and severity) to be included in the initiative, the type of interventions required, the health benefits expected for this group and the marginal costs of achieving this benefit.

### **2.1.1 Current priorities**

It is proposed that all existing patients in CCM programmes will be included in the new generic approach as of 1 July . This includes:

- 150 patient with diabetes
- 150 patients with COPD
- 150 patients with CHF
- 300 patients with COPD/asthma

Interventions for patients with these diseases have already been shown to be cost effective, either in local initiatives or overseas initiatives. The outcomes for these patients will be evaluated during the first year of their inclusion in the generic CCM programme. Based on these results the CCM policy group will then make recommendations as to whether more patients with these diseases should be included in the CCM programme.

The two next groups of patients to be potentially included in the programme are:

- patients with cardiovascular disease,
- patients with a heavy illness burden

Work is currently being done to estimate the cost effectiveness of interventions for people with various severity levels of cardiovascular disease.

Further suggestions which have already been put forward and require further analysis are depression and gout.

### **2.1.2 Needs analysis guide**

The needs analysis will vary according to the questions asked by the policy group, but the following tasks would normally expect to be included.

1. National health goals.  
Check disease or target patient group against nationally identified key areas of health needs and health gain, particularly in relation to Maori and Pacific health status.
2. CMDHB strategic plan.  
Check disease or target patient group against locally identified key areas of health needs and health gain, particularly in relation to Maori and Pacific health status.
3. Community needs analysis.  
Many community analyses have been done previously, by groups such as the Counties Manukau Health Council, the South Auckland Health "Think Tank" and Otara Health Inc, and may already have the information required. Being mindful that the community may feel over researched if necessary a community needs assessment can be carried out. Such a needs assessment would normally require at a minimum a focus group of a cross section of patients with the disease, and may also include a patient survey. The focus group can then become the patient reference group, providing guidance in the design phase of the project.  
Local patient health advocacy groups such as the Asthma and Respiratory Foundation, National Heart Foundation, Diabetes Society may also be engaged in the process.
4. Maori needs analysis.  
Arrange with the appropriate Maori groups to obtain information about their specific health needs.
5. Pacific Peoples needs analysis.  
Arrange with the appropriate Pacific Peoples groups to obtain information about their specific health needs.

6. Measure disease/illness burden – patient morbidity and mortality.  
Gather data on:
  - number of patients with the disease(s), number admissions and readmissions
  - number of deaths
  - rate of co-morbidities – both from admission and GP problem lists data
  - data available on quality of life
  - differences in Maori, Pacific and Asian levels of morbidity compared with New Zealand European
  - Patients admitted with a specified DRG over a specified time period including names, DOB, NHI number, ethnicity and usual GP can be obtained from SAH casemix team. Readmission rates and time of first readmission can also be obtained
  - A proxy way of identifying which patients have greater severity of disease is to use those patients who have been admitted within the last 2 years.
  - incidence of the disease in the general practice population as taken from Read coded problem lists
  - published epidemiological reports
7. Stratify patients by severity.  
The effect of any intervention will vary according to severity levels for any disease/pt group and hence this needs to be estimated in order to decide who will be targeted.
8. Describe existing services and access to those services.  
Compile a list of all available services for this disease or target group in secondary care, primary care, pharmacy initiatives, Maori initiatives, Pacific Peoples initiatives, and community initiatives. Describe what is supplied by each service, including any previous integration or chronic care management initiatives. Describe any access problems identified in discussions with the patient reference groups.  
Describe any problems with co-ordination between the existing services.
9. Estimate the gap between current care and best evidence care.  
Audit current health provider performance and compare this with current best practice as identified by national or international guidelines or results of a literature search.
10. Assess ability of providers to change and barriers to altering current practice.  
Hold discussions with a focus group of key providers (secondary care clinical staff, a group of GPs and practice nurses, home health care providers, community health workers) to determine how easy it would be to change current clinical practice and practice systems to achieve the desired outcomes.
11. Estimate projected improvement in quality of life as a result of the project.  
Reports of chronic care management projects done elsewhere often include changes in quality of life data. The discussions held with Maori, Pacific peoples and consumer groups will have provided information on the possible improvements that could result for individuals from chronic care management.

12. Estimate improved health status, morbidity and mortality.  
Information from for this analysis will normally be obtained from reports of similar initiatives done elsewhere.

### 2.1.3 Financial analysis guide

It is not possible to do a financial analysis of chronic disease management per se as cost and effects of CCM vary according to the nature of the specific initiative. Initial analysis may highlight areas of focus – e.g. the group / area of interest for a CCM programme with current high costs in secondary care such as COPD. In this case the goal may be to reduce hospital costs **and** improve patient health outcomes, while acknowledging the need to spend more in a system of care focussed in general practice. This is a dominant strategy if it proves true.

Adopting a generic approach to CCM allows for many of the programme costs to be standardised.

Types of analysis will vary depending on the situation and the decisions to be made.

A limited analysis may be valid where care is focussed on a subgroup of patients in whom care is less than ideal, and in whom the costs of care are currently large. In this case the reduction in costs in one area can be measured (e.g. admission costs) while the improved health outcomes are offset by a marginal increase in costs in another area (e.g. GP and nursing visits and pharmaceuticals).

CCM by its nature focuses on a group of patients with excess costs / excess burden of illness. The aim of reporting on the “return on investment” is to demonstrate that the benefits of the new system of care exceed the investment needed to implement the new system of care. Benefits may include reduced admissions, reduced readmissions, lower pharmaceutical costs, or lower laboratory costs.

In other cases a formal analysis may be required. Methodologies include:

- ◆ Cost-minimisation  
Where improved outcomes are achievable without increasing costs  
OR the same outcomes are achieved at lower cost – the answer will be obvious. In these cases the implementation of the new system of care will be dominant.

In many cases it is not clear whether the proposed new system is able to achieve improved outcomes at lower cost or better outcomes for the same cost. At other times there may be a choice between alternative new proposals for differing disease areas. In these examples a full cost benefit analysis will be useful to guide decisions.

- ◆ Cost-effectiveness  
Costs in dollars and benefits in natural units – e.g. \$ per heart attack avoided. This will be useful when comparing the treatment / prevention of a single disease by different processes of care but is not able to compare outcomes for different diseases.

- ◆ **Cost-utility**  
Comparison of benefits (health outcomes) using a common value – e.g. Quality Adjusted Life Years (QALY). This is useful where health outcomes can be converted to QALYs and compared across diseases, for prioritising proposals where competing demands for resources exist.
- ◆ **Cost-benefit**  
Converts all costs and benefits to dollar values. Methodology for this relies on assigning dollar values to benefits, which incorporates many biases.

In most cases a cost-minimisation approach or a cost-effectiveness approach will be used, because we are interested in improving the system of care for a single disease entity or target group. Thus new CCM programmes will aim to:

- lower overall costs for the same outcome
- OR improve outcomes for the same overall costs
- OR improve the cost-effectiveness ratio for a disease (e.g. a comparison of \$ per 100 COPD patients per year)

Also to be considered in the financial analysis are:

- ◆ **Discounting** – to value the future benefits in today's dollars
- ◆ **Cost utility or cost benefit analysis** will assist prioritisation and comparison of alternative programme target groups
- ◆ **Subgroups** – are resources better used if targeted at specific groups with greater need. Comparative analysis may be needed.
- ◆ **Perspective** – the perspectives of the payer, the provider and patients are valid at times. All should be considered when carrying out the needs and financial analysis.
- ◆ **Costs** – includes direct costs for the DHB, side effects of treatment, and other programme costs. Indirect costs such as productivity of patients is not relevant to the analysis. Direct patient costs / co-payments may be relevant.
- ◆ **Offsets** – from costs include those aspects of care which result in savings for the DHB. An adjustment for patient compliance / patient uptake may be included.
- ◆ Remember that as patients may well have co-morbidities we will need to estimate costs and benefits from treatments for the comorbid conditions.

## **2.2 Culturally competent systems and provider skills**

The Counties Manukau Region contains many diverse communities with a significant portion of New Zealand's Maori, Pacific, and Asian populations within the geographical boundaries. Maori comprise some 17% of the population and Pacific peoples some 16% of the population. The impact of poverty and ethnicity are reflected in measures of health status and deprivation in the region, with Counties Manukau having already identified the need to promote “interventions that address socio-economic disparities and culturally targeted services”<sup>1</sup>.

In order to meet the health needs of these disadvantaged communities, and in particular to ensure equal access and equity of health outcome, the issue of cultural competency by providers is being debated. As Maori and Pacific peoples are important target groups for Chronic Care Management, it is recognised that any new system of care being

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<sup>1</sup> Counties Manukau Health Profile – May 2001

implemented in this region will need to support cultural competency by providers. This is to ensure Maori and Pacific peoples have an enhanced opportunity to achieve health status comparable to other populations in the region.

Due to the emerging and developing nature of work in this area this paper is to be considered a 'work in progress' rather than the definitive view of cultural competence.

There is no one starting point with this journey as individuals and organisations are at various stages along the cultural competency continuum. Therefore this section is intended to outline the way forward for organisations and individuals who are providing services to people with long term health needs in the Counties Manukau region.

### **What is Culture?**

Culture has been described as the learned and shared patterns of information that a group uses to generate meaning among its members. These patterns encompass language, non-verbal communications, relationships with other people, beliefs and material goods. Within cultures the members share a belief in certain rules, roles, behaviours, and values, shaping the individual's worldview and influencing their interaction with others.

This definition applies to the medical culture which characterises the pattern of interaction between health care providers and patients from the majority cultures, as well as to the diverse cultures of the Counties Manukau community.

### **Defining Cultural Competency**

A set of academic, experiential and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on the values, traditions, and customs of other cultural groups, and to work with knowledgeable persons from other cultures in developing targeted interventions, communications, and other supports.

### **Why is Cultural Competency important?**

The motivation for providers to address cultural competency arises from consideration of the following goals that relate to reducing disparities, achieving Crown objectives, and meeting patient/community defined requirements;

- To meet the health needs of people in the Counties Manukau region
- To achieve equity of health outcome for the diverse populations of this region
- To meet Crown objectives for the health of Maori and Pacific peoples
- To meet the patient defined requirements for quality health services
- To meet Crown obligations to Maori

There are many opportunities for health care interventions to give rise to confusion when providers and patients with differing cultural backgrounds interact. The relationship between 'culture' and the interpretation and outcome of disease has been well

documented, with public health studies consistently show improved health outcomes as providers' bridge cultural gaps between themselves and their patients.

The following points illustrate the need for developing cultural competency at a provider-patient level.

- Communication and understanding lead to improve diagnoses and treatment plans, and the improved patient satisfaction leads to greater compliance with those plans
- Cultural competence allows the provider to obtain more specific and complete information to make an appropriate diagnosis
- Cultural competence facilitates the development of treatment plans that are followed by the patient and supported by the family
- Cultural competence reduces delays in seeking care and allows for improved use of health services
- Cultural competence enhances overall communication and the clinical interaction between the patient and provider, leading to improved satisfaction for both the patient and the provider
- Cultural competence enhances the compatibility between Western and traditional cultural health practices. Cultural competence and building healthy communities through community development programmes go hand-in hand

**These are based on the following principles:**

- Consistent collection of ethnicity data in an approved manner underpins the delivery of culturally competent health care to individuals and communities;
- There is diversity within cultures as well as the diversity between cultures;
- Concepts such as “family”, “community”, “wellness”, and “illness” are different for various cultures and the meanings of these are contained within the language and customs of each culture
- The perception of illness and disease and their causes varies by culture
- Diverse belief systems exist related to health, healing and wellness
- Culture influences ‘help seeking’ behaviours and attitudes toward healthcare providers
- Individual preferences affect traditional and non-traditional approaches to health care
- Patients must overcome personal experiences of biases within healthcare systems
- Patients are best served by persons who are a part of or in tune with their culture
- Providers need to be both culturally competent and clinically competent to be effective
- Cultural competence requires a commitment to continuous improvement through continuing education, review, and feedback, in the same way that clinical competence does
- Healthcare providers from culturally diverse groups, in particular Counties Manukau populations with poor health outcomes, are under-represented in the current service delivery system
- Culture shapes the behaviours, attitudes and values of health care providers and their institutions

- In addition to the consideration given to methods for improving clinical interventions, cultural competence requires culturally competent methods for satisfaction surveys, complaints processes, and other non-clinical communications<sup>2</sup>.

## 2.2.1 Maori plan

### Background

There are many opportunities for health care interventions to give rise to confusion when providers and patients with differing cultural backgrounds interact. Advanced technologies and diagnostic tools cannot replace clear patient-provider communications, when accurate disease prevention, diagnosis and treatment planning is at stake. If patients do not receive advice in a manner or language that is understandable, they may not be prepared physically or psychologically to undergo these sometimes painful and frightening procedures. Likewise, if patients are to comply with a treatment plan or lifestyle change, they must have a clear understanding of what is required of them.

### Maori Views

In particular the Maori worldview places greater emphasis on group consensus than Pakeha culture, and the Maori view of health incorporates a steady-state where personal wellbeing is integrated with spiritual, family, community, social, and mental well-being. Key to this integrated sense of wellbeing is the concept of *tapu* and *noa* – a balance between the profane and the ordinary that guides daily living. A Chronic Disease Management programme will need to carefully address these aspects of Maori identity to be effective.

Cultural Competence requires that providers have a willingness and ability to draw on the values, traditions, and customs of other cultural groups, and to work with kaumatua and other knowledgeable persons from Maori communities in developing targeted interventions, communications, and other supports.

Culturally competent care adds value to the health care delivery system by demonstrating improvement in quality of care, such as better outcomes, greater client satisfaction, increased access, greater provider satisfaction, and other aspects of enhanced value.

Both health providers and patients bring their respective cultural backgrounds and expectations to the health care setting. These cultural differences can present barriers to appropriate care. It is common for mainstream providers in New Zealand to be a member of a cultural group that is accustomed to the Western emphasis on the individual. However, in many other cultures, including Maori, the family plays the central role in daily life including illness.

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<sup>2</sup> National Centre for Cultural Competence, Georgetown University – “Rationale for Cultural Competence in Primary Health Care

Illnesses can be categorised in strictly biological terms by mainstream medicine, but many Maori carry cultural assumptions that may influence the presentation of symptoms or the response to diagnosis and treatment. A patient whose culture does not have a model for chronic diseases that fits with the mainstream model of illness may perceive little benefit in a programme of lifestyle change and medicines to manage asymptomatic disease today against a potential advantage some time in the future.

### **Additional principles for culturally competent care for Maori**

- Concepts of illness and health are encapsulated in Maori language and customs (te reo and tikanga)
- Linkages to Maori healthcare providers and to Maori staff members (staff with responsibility for delivery of health care to Maori) in mainstream health care providers will can enhance the integration of care by sharing knowledge about patients and communities, and by locating issues that require improvement

### **Skill requirements, needs & methodology**

#### **1. Values, staffing & training**

Ideally, the patient should have providers of the same cultural background available. Alternatively providers with appropriate training and empathy for the cultural background of the patient can provide care. The provider / programme should promote and support the attitudes, behaviours, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse environment. Arrange for ongoing education and training for administrative, clinical, and support staff in culturally competent service delivery, including the dissemination of accurate information on the health needs and cultural practices of relevant communities to improve care and dispel stereotypes about Maori.

Develop and implement a strategy to recruit, retain and promote qualified, culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the communities being served. The starting point for such a strategy is to employ staff that reflects the cultural diversity of the community being served, and this will require innovative search and recruitment strategies.

#### **2. Programme policies**

Have a comprehensive management strategy to address culturally appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

#### **3. Community involvement**

Establish mechanisms for Maori involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, treatment planning. Such involvement needs to start prior to the beginning of the programme (concept development) and continue through all aspects of the programme, including evaluation and feedback of performance. A culturally competent programme will be building upon relationships already established with Maori communities, kaumatua, and Maori health providers through attendance at hui, tangihanga, and other community events that celebrate the resilience of Maori.

#### **4. Language and resource materials**

Maori should have access to bilingual staff or interpretation services. This will include the provision of oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of availability of interpreter services.

Translate and make available signage and commonly-used written patient educational material and other materials for Maori.

#### **5. Data collection**

Ensure that the clients' self-identified ethnicity (including all iwi and hapu that are relevant to the individual) are included in the patient information management systems as well as any patient records used by provider staff. This data is to be collected in an approved and consistent manner. Collect, report and use accurate demographic, cultural, epidemiological and clinical outcome data for Maori, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

#### **6. Complaints**

Develop structures and procedures to address complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services. Use complaints and critical incidents as learning opportunities for the organisation, including as a basis for discussion with kaumatua for analysis and for service improvements.

#### **7. Assessments & satisfaction**

Undertake ongoing organisational self-assessments of cultural competence. Where validated and culturally appropriate measures of access, satisfaction, quality, and outcomes for Maori and other ethnic groups are available, integrate these into organisational internal audits and performance improvement programs.

#### **8. Relationships with Maori providers**

Maori providers can provide valuable linkages between communities, patients and mainstream providers. Even where the majority of Maori access mainstream providers, the kaupapa Maori units of secondary care providers and the staff of Maori primary care providers have special expertise in the care of Maori patients, which should be utilised in the same way that expertise in clinical areas can be shared.

#### **9. Evaluation and improvements**

Complete and make available reports documenting the organisations' progress with implementing these criteria, including information on programme outcomes, performance indicators, staffing, complaints, training, and resources used.

#### **Conclusion**

Cultural competence is to be regarded as quality journey where the results of all of the points noted above (from Values to Evaluations) are integrated into a cycle of continuous service improvement that will make culturally competent care available to Maori.

At some point each service / provider will be able to describe best practice in terms of clinical and cultural competence for chronic disease management.

## 2.2.2 Pacific Plan

### **“OUR PACIFIC”**

*Vaine Rasmussen*

*Te Rau Maire: Poems & Stories of the Pacific*

#### ***Pacific***

There is not one Pacific  
There are many  
From the solid slopes of Mount Hagen and  
    Porgera's wealth in the west  
To the Pearl locked islets of  
    Tuamotu's east  
From the chilly tips of Maoridom south  
To the borders of the Northern territories  
    And her mysteries that span from  
    equator  
to cancer

There is not one troubled region  
There are many  
Trade links and nuclear free zones  
    Cohabit with foreign assistance  
    And internal discord  
My sister does not speak with me anymore  
And old ways of doing things are  
    Re-looked at  
Children go to far away places  
    And balsa pits lie idle and still

There is not one Pacific  
Only one common theme  
That development is certain  
    Though foreign  
And coconuts will continue  
    To fall  
The Pacific Ocean will camouflage  
    superficial dreams  
And the faint sound of drums  
    Will still be heard  
If we pause a while to listen

# Pacific Competency

## Introduction

Terms to describe people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of ancestry or heritage vary considerably (e.g. Pacific Island, Pacific Nations person, Polynesian, Pacific Islander etc.) There is no officially sanctioned term to describe this group of people. Since 1994 the Ministry of Pacific Island Affairs has used the term “Pacific peoples” to describe this group.

The term “Pacific peoples” does not refer to a single ethnicity, nationality or culture. The term is one of convenience used to encompass a diverse range of peoples from the South Pacific region and is used in this document to include those who self identify as a Pacific nation ethnicity<sup>3</sup>.

Pacific peoples are culturally and ethnically diverse. It is estimated that Pacific peoples living in New Zealand represent over 20 Polynesian, Melanesian and Micronesian cultures, speaking an even greater number of languages.

Pacific peoples have been in New Zealand for over 100 years. In 1945 Pacific peoples comprised 0.1% of New Zealand’s population. Pacific peoples are diverse in culture and languages, but share common migration and assimilation history in New Zealand. The migration of Pacific peoples increased rapidly in pace during the 1960’s a period of brisk economic growth and high demand for labour in New Zealand.

Today Pacific communities are no longer solely immigrant communities. Sixty percent (60%) of Pacific peoples residing in New Zealand are New Zealand born, with a median age of 11.4 years<sup>4</sup>.

Pacific peoples in New Zealand have made changes to their lifestyles. Changes have sometimes meant total immersion in New Zealand lifestyles, others have taken the best out of tradition and modern lifestyles and some have endeavoured to retain solely traditional lifestyles. There is an ongoing tension between adapting to change and retain traditional values, lifestyles and attitudes.

Second and third generation New Zealand born Pacific peoples are often torn between the value systems of the country they are born into and the traditional expectations placed on them by their immigrant parents or grandparents.

Most Pacific cultures regard the extended family structure as central to the way of life and identity is often reinforced through family or kinship relationships, village and island.

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<sup>3</sup> Ministry of Pacific Island Affairs – “Pacific Directions Report 1999”

<sup>4</sup> Ministry of Pacific island Affairs – “Pacific Directions Report 1999”

Spirituality is a fundamental component to most Pacific cultures and is expressed in a Christian sense as well as in a traditional preservation and remembrance of ancestral ties and origins. The 'Church' remains an integral part of most New Zealand Pacific communities.

Non Church based Pacific organizations and networks have developed over many years and contribute maintaining the 'connectiveness' of each Pacific group and provide invaluable support to communities.

Pacific cultural competency is a continuation of the journey of our ancestors providing opportunities and experiences that are as yet undiscovered.

### **Why 'Pacific' Cultural Competency**

The question is often asked regarding "why focus on Pacific competency?" This section identifies some key principles around which this decision was made for the Counties Manukau region.

- To respond to the current and projected demographic changes in Counties Manukau region.
- To eliminate long standing disparities in the health status of Pacific peoples
- To improve the quality of services and health outcomes
- To meet Crown objectives

- *To respond to the current and projected demographic changes in Counties Manukau region.*

1996 Census data states that 62,000 or 27% of New Zealand's 227,000 usually resident Pacific people lived in Counties Manukau, comprising sixteen percent (16%) of the total Counties Manukau population. Half these people were Samoan (27,900 or 51%) with Cook Island people (11,300 or 21%) and Tongan people (8,800 or 16%) being the next largest groups.

Fifty percent (50%) of the Pacific population live in Mangere, Papatoetoe or Otahuhu, 27% in Otara and 17% in Manukau or Manurewa.

Young people are over represented with 55% of the Pacific population under 25 years compared to the New Zealand average of 36%. Older people are under-represented also making up 3% of the over 65 year old population compared with the New Zealand average of 12%. In addition to this the total fertility rates continue to stand at 3.3 for a Pacific women compared with 1.8 for non-Pacific, non-Maori.

The projected growth rate of the Pacific population is 80,200 – (+29%) in 2006, 93,200 – (+49%) in 2016 and 101,600 – (+63%) in 2021.

In Counties Manukau the second most commonly spoken language is Samoan<sup>5</sup>.

- *To eliminate long standing disparities in the health status of Pacific peoples.*

Nowhere in New Zealand is the disparity between Pacific people and other New Zealanders more graphically represented than in Counties Manukau. Despite recent progress in specific areas of health status the continuing disparities for Pacific populations are evident in illness, morbidity or mortality rates.

- Life expectancy 

69.8	male	Pacific
75.3	male	Non Pacific/Maori
75.6	female	Pacific
80.6	female	Non Pacific/Maori
- Burden of disease in Pacific communities disproportionately falls on younger people
- Pacific population in Counties Manukau has the highest rate of unavoidable mortality even compared with Pacific communities in other areas.
- Pacific children are the highest users of paediatric medical services
- Pacific children have higher rates of avoidable admissions
- Respiratory infections, ENT infections, Gastro-enteritis and Asthma are the four leading causes of potentially avoidable hospitalisations for 0-14 year olds
- 52% of all Pacific babies born in Counties Manukau were admitted to hospital at least once under the age of 1 year
- Immunisation rates are 55% for 2 year olds
- Highest rates for meningococcal disease, measles, rheumatic fever, rheumatic heart disease and obesity
- High rates of diabetes, cardiovascular disease, tuberculosis, liver cancer and sudden infant death syndrome
- High morbidity for young people with accidents and injuries

Although the reasons for these disparities are not well documented it is clear that socio-economic status, unemployment, housing and the failure of organisations to provide culturally competent healthcare are all contributing factors<sup>6</sup>.

- *To improve the quality of services and health outcomes*  
Despite similarities between Pacific populations fundamental differences arise from ethnicity, family background and individual experiences. These differences affect the health beliefs and behaviours that both patients and providers have of each other.

In making a diagnosis, health care providers must understand the beliefs that shape a persons approach to health and illness. Knowledge of customs and traditional healing practices are indispensable to the design of treatment and interventions.

Healthcare services must be received and accepted to be successful.

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<sup>5</sup> Counties Manukau District Health Board, Counties Manukau Health profile – A Summary of Health and Healthcare Information for the Counties Manukau People – May 2001

<sup>6</sup> Counties Manukau District Health Board, Counties Manukau Health Profile – A summary of Health and Healthcare Information for the Counties Manukau People – May 2001

- *To meet Crown objectives*

The New Zealand Health Strategy states under Principles

“An improvement in health status for those currently disadvantaged”

“... an increase in effort is needed to address the low health status of groups with low socio-economic status, including Maori and Pacific peoples and people with serious mental illness under goals:”

In the section relating to goals it states:

“Reducing inequalities in health status

- Ensure accessible and appropriate services for Pacific peoples
- Strengthening primary health initiatives for Pacific peoples
- Improving the health of Pacific children
- Improving mental health services for Pacific peoples
- Enhancing screening programmes to improve the health of Pacific peoples
- Increasing the number of Pacific peoples in the health workforce”<sup>7</sup>

### **Pacific “Cultural Competency”**

The following definition describes Pacific cultural competency:

“The ability to incorporate Pacific values, principles, structures, attitudes and practices in the care and delivery of services to Pacific patients, their families and communities. Cultural competence at both the organisational and individual levels is an ongoing developmental process. Therefore cultural competence must be systematically incorporated at every level of the organisation including policy making, administrative practice and patient, family community levels.”<sup>8</sup>

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<sup>7</sup> Ministry of Health – New Zealand Health Strategy December 2000

<sup>8</sup> South Auckland Health – Pacific Cultural Competency Paper to Clinical Board

## Pacific Cultural Values

The following Pacific values may be used as underlying principles for providers. Languages of the four major Pacific groups have been used in addition to Te Reo Maori and English.

Maaori	English	Samoan	Tongan	Cook Islands	Niue
<i>Mihia, Whakaute</i>	Respect	<i>Fa'aaloalo</i>	<i>Faka'apa'apa, Feveitokai'aki</i>	<i>Akangateite, Taakaaka</i>	<i>Fakalilifu</i>
<i>Arohaina, Aroha</i>	Love	<i>Alofa</i>	<i>'Ofa</i>	<i>Aroa</i>	<i>Fakaalofa</i>
<i>Mana Whakahaere, Kawenga, pikaunga</i>	Responsibility	<i>Tiute tauave</i>	<i>Fatongia, Ngafa</i>	<i>Ei Tavini, Rimarave</i>	<i>Kotofaaga ke Leveki</i>
<i>Mahi Tika Mahipono, Pononga</i>	Honesty	<i>Fa'amaoni</i>	<i>Faitotonu</i>	<i>Tuatua Tika, Pikikaa Kore</i>	<i>Mahani Fakamooli</i>
<i>Kaingaakau, Tukua Tokomauri, Aurere</i>	Commitment, Passion	<i>Tu'uina atu atoa</i>	<i>Ngau'e 'osi kia velenga</i>	<i>Akaatingaanga</i>	<i>Fakamooliaga</i>
<i>Nga Taha Wairua</i>	Spirituality	<i>Loto atoa ma le agaga</i>	<i>Laumalie</i>	<i>Irinaki Atua</i>	<i>Moui Fakaagaaga</i>

## Pacific Culturally Competent Practices

Culturally competent healthcare practices are important to Pacific patients and family. The following are examples of culturally competent healthcare practices for working with Pacific Peoples:

- Healthcare practices that are grounded in Pacific peoples values of respect, love, responsibility, honesty, commitment or passion, and spirituality.
- Practices that acknowledge that the Pacific patient is a member of an extended family and community. Family members and community e.g. Village, church are often involved with the decisions regarding healthcare plans and management, and assist in the care giving. Knowledge of the relationships between caregivers and patients will enable staff to understand, adopt and practice appropriate behaviours and protocols.

- Practices that provide information in the Pacific patient's first language and enables them to communicate clearly with staff. This requires access to qualified, professional interpreting and translation services to ensure that Pacific patients and their families are well informed and are able to participate in their care.
- Practices that acknowledge that there may be differences between health professionals' views of health, wellbeing, healing and quality of life, with that of Pacific patients and their families, may lead to staff working alongside church ministers and traditional healers with the aim of improved health outcomes for Pacific patients.
- Practices that seek to improve the quality of services and strategies for working with Pacific peoples.
- Practices that recognise traditions and protocols in palliative and bereavement care.

## **Where to From Here – The journey**

### **1. Staffing and training**

Key components of Pacific cultural competency will include but not be limited to:

- Pacific peoples' cultures and the differences within each ethnic group including an understanding of race, ethnicity and power.
- Pacific peoples' families, structure, inter generational relationships, networks and how these relationships, networks and how these influence health behaviours including 'New Zealand born' vs 'Pacific born' behaviours.
- Pacific peoples' views of health, wellbeing, healing, quality of life and utilisation of healthcare services and help seeking patterns
- Historical factors which impact on the health of pacific populations such as immigration patterns, racism (as noted in Monitoring Ethnic Inequalities in Health, MoH 2001<sup>9</sup>) resettlement in New Zealand, citizenship rights, cultural adaptation and colonisation of pacific nations.
- Psycho-social stressors experienced by different Pacific groups and sub-cultures within ethnic groups including 'culturally acceptable' behaviours of psycho-pathological characteristics.
- Traditional healing practices within each ethnic group.
- Role of religion, church and the church hierarchy and structures including the concepts of spirituality.
- Definitions of common Pacific values and concepts such as respect.
- Pacific peoples health status and differences between ethnic groups.
- Priorities for Pacific peoples health improvement.

Ongoing training for all staff to continue to build on experience is critical both in a technical knowledge based sense and also in an experiential process. An evaluation framework to monitor the effectiveness of the training and refine the programme is also useful.

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<sup>9</sup> Ministry of Health – Monitoring Ethnic inequalities in Health 2001

Providers should endeavour to engage staff who reflect the diversity of the Pacific population served. Therefore recruitment, selection and retention of staff who value, respect and acknowledge Pacific people and/or communities in these key processes often deliver more successful outcomes.

## **2. Measuring Cultural Competency**

Developing standards and measures of cultural competency is an important step on the journey. It enables providers to recognise and reward staff who add value in this area and to measure effectiveness. It should be a key component in the performance management system of the organisation.

## **3. Programme policies**

Strategic plans, goals, policies and procedures will identify key areas for implementation that will be measurable in improving health status and maximising health gain for Pacific peoples. This will involve identifying key individuals to take responsibility and drive cultural competency strategies. It will also identify key strategies to engage Pacific peoples in programme development.

## **4. Community engagement**

It has become clear that individual health is closely linked to community health, community health is profoundly affected by the collective behaviours, attitudes and beliefs of everyone who lives in the community. Partnerships can be an effective tool in improving health in Pacific communities. The complex nature of Pacific communities in Counties Manukau require leadership approaches that are multi-faceted and culturally competent. Cultivating leadership capacity is an indispensable strategy for engaging Pacific communities to reduce disparities in health status.

Key points in working with Pacific communities will include:

- Establishing and maintaining trust with Pacific communities and the Pacific health sector when there may be a history of adversarial relationships or distrust.
- Effectively sharing resources with competing needs.
- Sharing power and ensuring contributions are valued and respected.
- Using culturally competent communication modalities to provide Pacific partners with timely access to information.
- The most fundamental principle to consider when engaging Pacific communities is the inherent ability of communities to recognise their own problems, including the health of its members and intervene appropriately on their own behalf.

## **5. Language and Resource Materials**

Language and custom are the cornerstones of maintaining cultural integrity. Therefore the support and promotion of 'first languages' is an important principle. The interpretation of cultural perspectives with regard to illness and health is also integral in diagnosis and treatment plans.

Providers ideally may have staff bilingual in key Pacific languages and will have access to accredited interpretation services. Patients and families will also have available key health information in translated format.

Resource materials will be developed in partnership with Pacific communities that will consider cultural sensitivities and appropriateness both in design and use of messages.

## **6. Data collection**

Data will be collected that will identify ethnicity. Ethnicity will be recorded in a consistent manner with NZ Statistics guidelines. Staff will be trained and supported to collect data and regular audits will be undertaken to ensure compliance. Data will be used to measure and review programme effectiveness, uptake of population groups and provide planning information.

## **7. Complaints**

Providers will develop a complaints and feedback system and process that will support Pacific individuals, families and communities. A key principle will be the approach of utilising the complaints and feedback system as a quality improvement mechanism. Flexibility should be a key feature that will allow traditional Pacific custom to be applied where necessary i.e. meeting with extended families, using key community members as advocates.

## **8. Assessment and satisfaction**

Undertake ongoing organisational self-assessments of cultural competence. Where validated and culturally appropriate measures of access, satisfaction, quality, and outcomes for Pacific peoples are available, integrate these into organisational internal audits and performance improvement programs. It is important to recognise the appropriateness of method i.e. verbal vs written etc.

## **9. Relationships with Pacific providers**

Pacific providers, churches and organisations can provide valuable linkages between communities, patients and mainstream providers. Pacific staff within mainstream organisations have expertise in managing relationships with Pacific families and may provide valuable assistance and support. Pacific providers are perceived as having a leadership role in the health sector therefore may be a valuable resource and partnership.

## **10. Evaluation and improvements**

Document the organisations' progress with implementing these criteria, including information on programme outcomes, performance indicators, staffing, complaints, training, and resources used. Evaluation models must incorporate Pacific competency and utilise staff with particular skills in this area.

### **Conclusion**

Pacific cultural competence is a process that will involve over an extended period. Individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

It is hoped that his paper will provide support for those already embarked on the journey and will provide inspiration for those contemplating change.

We acknowledge the contributions, feedback and inspiration from Pacific individuals, providers and communities who have helped shape this document.

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## 2.3 General practice team skills

### Principles

- Welfare of the patient including good health outcomes
- Patient and whanau/family centred consultations and practice systems
- Effective consultation and communication skills for doctors and nurses
- Patient and family empowered and informed
- Continuous improvement to cultural competence
- Co-ordination and continuity of care between providers to minimise numbers of staff patients need to relate to and facilitate sharing of information without unnecessary duplication
- Evidence based treatment appropriately delivered with decision support from clinical guidelines
- Professional development factored into mainstream practice
- Continuous evaluation, audit and feedback

### Skill Requirements

Ideally, the patient should be the primary manager of their chronic disease, guided and coached by health care workers to devise the best therapeutic regime.

Skills required by providers include:

- A patient centred approach that ensures patients are given the degree of control they feel comfortable with and that common ground is reached
- Consultation skills that include good listening skills and enhance communication
- Ability to form a supportive relationship with the patient and whanau/family
- Strong knowledge base and ability to access current information about diseases in term of epidemiology screening, prevention, pathology and treatment options for cost effectiveness
- Skills and tools for influencing behaviour change, including motivational counselling techniques
- Recognition and appreciation of health and other beliefs of cultures and their influence on self management
- Skills and tools for care planning
- Effective methods of communication with other members of practice team
- Effective methods of communication with health professionals outside practice
- Flexible and pragmatic approach to management to account for normal variations and uncertainties in medical practice at patient level
- Leadership skills along with recognition of the contribution by all members of the practice team
- Ability to recognise innovative possibilities for more productive interactions - accept changes in established organisation and practice

## 2.4 General practice systems

### Principles

- Patients are enrolled with their preferred primary provider who then takes responsibility and accountability for assisting them manage their chronic diseases
- Access barriers related to cost to patient, availability and cultural competence are removed
- Barriers to equity of health outcomes for patients are removed
- Practice record systems are able to identify both patients with common chronic diseases, and their demographics
- Each practice designs a patient flow plan for patients with chronic disease that is responsive both to the needs of their enrolled population and their available staff and resources.
- The patient flow plan is based on ensuring that key processes and outcomes from the clinical guidelines and project specifications are implemented.
- The practice staff work together as a team to provide the necessary care
- The practice has links to 24 hour care
- Primary care organisations (PCOs) / IPAs or structures put in place by grouping on nonaligned practices provide direction and support to the practices to enable them to participate
- All general practices will be encouraged to join the chronic disease management programme, with assistance available to help them improve their systems to meet requirements
- The practice relates to other primary care organisations and to secondary care to obtain enhancements to the care they provide to patients.
- Information technology supports and enables practice systems

### Methodology/Requirements

General practices will need the following systems and capabilities to provide CCM well. Extra funding and support for practices will be available to assist them reach this level in their first year of involvement in the programme. Ongoing involvement will require continuation of these standards.

- Patient enrollment systems encourage each patient/whanau to enroll with one practice team as their preferred provider. This process includes:
  - Patient Registration
  - Information to patients about Privacy and Information sharing
  - Obtaining permission to obtain information from other providers
  - A “contract” or simple agreement on the roles and responsibilities of patient/provider
  - Free/subsidised health care for patients enrolled in chronic disease management

- Systems in place to improve cultural competence. Such systems include:
  - practice policies for improving Maori and Pacific Health
  - planned, ongoing training in cultural competence for all staff
  - consistent recording of ethnicity according to agreed standards
  - ensuring there is sufficient space for the whanau in the waiting room and consultation rooms
  - patient education material in Maori, Pacific languages and Chinese
  - links to the community kaumatua established and supported with Maori input sought into delivery of CCM
  - links to the Pacific community established and supported with Pacific input sought into delivery of CCM
  
- Disease Registers
  - For non computerised practices disease registers for Asthma, COPD, diabetes, IHD, CVD risk, CHF, hypertension, hyperlipidaemia in the first instance.
  - Computerised doctors have in place Read coded problem lists
  
- Patient registration systems that capture the following demographics
  - Age/Sex
  - Ethnicity
  - NHI
  - Socioeconomic Status (CSC or NZDep 96)
  - Contact Details (address, phone, email)
  
- Easy access to and shared knowledge of patient resources
  - Education material
  - Education programmes
  - Patient held care plans
  - Community resources
  
- A patient Flow Plan for CCM patients, based on the guidelines and contract specifications for each disease (e.g. expected examinations, investigations, medications, patient education) in the programme, that interprets who, how and when the activities will be carried out within the practice. This will be done in a way ensures information sharing, shared management goals and plan, and an understanding of the overall plan by both the patient and the whole practice team. The details of the patient flow plan will vary from practice to practice according to their patient population, staff and resources. It includes:
  - Simple effective systems for identifying CCM patients when their chart is first opened by any staff members
  - recall systems to ensure patients receive regular care and no patient falls between the gaps
  - alert systems that identify any overdue tasks and activities
  - systems to encourage patients to see the same GP/PN each time
  - systems to ensure that the advice and patient education is consistent
  - time for patient education
  - tools for pt education such as the generic patient held care plan, and disease specific educational materials

- patient support groups
  - systems to allow patients to choose to when to have their education
  - systems to enable patients to choose referral to another provider, of the same ethnicity as themselves, for their education e.g. CHW
  - clinical tasks lists scheduled over the year e.g. clinical review activities such as investigations and examinations
  - annual review of medications
  - systems to access pharmacist medication reviews
  - easily accessible clinical decision support material. Including computerised decision prompts for key clinical decisions
  - systems to access required investigations directly from general practice e.g. echocardiograms
  - flexibility of delivery to allow for real patient behaviour e.g. patients who drop in rather than attending for specific appointment times
  - IT systems to assist with the above
- A well functioning practice team will have:
    - CCM Project Manager for each initiative
    - it is expected that practices will have practice nursing staff as part of the team
    - regular team meetings
    - in house review of performance and continuing improvement
- Evaluation and audit.
    - collection of data on agreed KPIs for chronic disease covering processes and outcomes, for both reporting and peer review purposes
    - KPIs to be kept to the minimum necessary for reporting and education to ensure that time is not borrowed from interactions with the patient for form filling
    - Practice systems that support easy audit of the process
    - GPs and PNs with commitment to and knowledge of their use
- Financial Systems
    - general practice visits free to patient (minimum of one free assessment visit for low deprivation areas, varying up to funding of all regular visits and urgent visits for low socioeconomic families.
    - HUC or CSC for all CCM patients to ensure maximum pharmacy bill is \$60 per year, with beneficiaries able to obtain an allowance to cover this amount
    - education and quality improvement time for GPs PN and CHW is paid for
    - practice management time to implement and manage CCM projects is paid for
    - The costs are estimated and then the practice paid per patient in the CCM programme on a capitation basis and is accountable through measurement of agreed KPIs

- IPA/PCO direction and support for:
  - education regarding the guidelines
  - peer review systems and activities
  - ongoing CME , feedback and improvement of the process
  - collecting, analysing and reporting on project KPIs
  - translating guidelines into patient flow plans
  - training staff members in design of practice systems
  - nurturing and bringing on board those practices who are slower to adapt to the new processes to ensure that their patients also benefit
  - assisting practice teams who are not functioning well
  - altering computerised clinical records to allow for easy collection of data.

Nonaligned practices may form groupings to arrange for these functions to be provided for them, but for simplicity the document will usually refer to IPA/PCO groups.

- Multi-disciplinary teams with seamless patient interface between the following providers
  - General Practitioner
  - Practice Nurse
  - CCM Specialist Nurse – in a project support role, as an extra resource to the GP and PN
  - Community Health Worker – in a project support role shared between practices to provide assistance to patients in regards to cultural and belief systems, attitudes to self care and disease management, healthy lifestyles
  - Maori providers
  - Pacific providers
  - Primary care organisations providing support as above
  - Community support groups and organisations
  - Pharmacists
  - Secondary Care Specialist
  - Secondary Care Nurse
  - Secondary Care Home Care

## 2.5 Guidelines and Education of GP, PN CHW and patients

### 2.5.1 Disease guidelines

#### Principles

- *Disease guidelines*, which specify the key evidence based clinical and self management activities for each disease, are multi-disciplinary and agreed to by all providers.
- *Disease guidelines* underpin all interventions, with each provider applying the guidelines according to their model of care and area of responsibility.
- Disease guidelines while being used to inform management decisions with patients and their families, will be used in a way that is sensitive to the beliefs, values, culture and socioeconomic status of the patient and their family
- As new national guidelines are produced for common chronic diseases these should be analysed to determine where the key areas of change are for patient management and an education and audit process put in place to bring general practitioners and practice nurses up to speed with the changes they need to make.

#### Methodologies

The project team for any CCM initiative assesses the current guidelines available locally and internationally and wherever possible selects an existing guideline for adoption. Such a guideline should be evidence based, up to date, relevant to Counties Manukau, and cover both clinical and patient self management activities. A multidisciplinary group may need to update, adapt or complete the guidelines, avoiding, if possible developing guidelines from scratch.

Consultation with primary and secondary care providers to obtain endorsement of the proposed guideline is important for provider buy-in.  
Endorsement process

Each of the following will be written in concordance with the guideline.(practice systems)

- GP educational material
- Computerised decision support
- PN educational material
- Patient educational material
- Secondary clinical care pathways
- Necessary processes for general practice management and patient education which will be incorporated by practices into their patient flow plans
- Patient held care plan
- Patient questionnaires

For many of the above more general issues will be included in addition to the guideline evidence.

## **2.5.2 Patient education and empowerment**

### **Principles**

Education of patients focuses not only on the physical aspects of their illness or disease, but also addresses the effects on the whanau/family (Whanaungatanga), the emotional aspects (Te Taha Hinengaro) and the spiritual aspects and meaning of the illness in their lives (Te Taha Wairua).

Patient education aims at empowering patients to take as much responsibility for managing their overall health needs and illness as they feel able to. There is a shift from doing things 'to' the patient, to working out management plans 'with' the patient.

Patient education focuses on the patient's total health, rather than a specific disease.

Patient education is usually best done by someone who speaks the patient's first language and has the same cultural background.

Providers working cross-culturally need to communicate with patients in a way that respects their culture and value systems.

Patient education is usually best carried out by a provider who has an ongoing relationship with the patient.

### **Methodologies**

#### **Community consultation**

Community consultation is important, including input from the major ethnic groups, is necessary for highlighting important areas to cover in the design of patient education materials

#### **Patient knowledge assessment**

When assisting individual patients and their families it is important to assess their current understanding of their illness as a basis for providing further education. This may be done using patient questionnaires or through semi structured discussion with the patient.

Such assessments are thought to be more accurate if done by someone of the same ethnicity

Such assessments are usually best carried out by or with the assistance of their usual health provider team. This helps build the relationship between the patient and provider and provides the basis for ongoing discussions and education.

### **Patient held care plan**

The patient held care plan contains a coordinated summary of the management of all their chronic conditions including, current medications, lifestyle goals, monitoring activities and action plans. The plan is developed with the patient, is kept by the patient and may be updated by any provider.

Written Patient Held Care Plans are provided to all patients to assist them in self care.

The written plan should contain as a minimum:

- Patient, GP and after hours contact details
- Information about the purpose of the plan
- List of current health conditions
- List of current medications (what they are for, when to take each one)
- Lifestyle goals
- Information about their diseases
- Action plan for what to do if their condition deteriorates
- Chart to record any self monitoring activities e.g. weight, glucose
- Schedule for regular monitoring activities to be carried out with the GP/PN
- Schedule for future appointments or tests

SAH and primary care have already developed, with community input, a standard Patient Held Care plan for all chronic disease management projects, translated into Maori and four Pacific languages.

### **Patient education**

Usually the education will be provided by the general practitioner and practice nurse working as a team, with most of the time spent by the practice nurse.

The practice nurse must have dedicated time to spend with CCM patients on health education. (at this point given limited evidence and the need to work towards developing costings it is suggested that a minimum of 30 minutes four times a year is required for CCM).

Maori and Pacific patients may prefer a group co-operative learning model with support from whanau/family.

Patients should have the choice of receiving their education from someone of the same ethnicity or who speaks their first language. Dependent on resource availability.

Where available/ applicable community health workers (CHW) and disease management nurses will encourage self management strategies within the community.

Community health workers are community and family based, working with the family and the community to promote wellness and self management across all chronic diseases.

Community health workers have generic skills in assisting the family and local community. They will apply the self management aspects of the guidelines in their interactions with families.

If a CHW or DM nurse is involved then close liaison with the GP/PN team should occur.

**Recommendation:** that funding be allocated to scope the establishment of a cadre of Pacific CCM community health workers linked in with mainstream general practice. Included will be a review of how the Maori DM nurses relate to general practice. Scoping to be completed by end December 2001 with the system piloted in the first six months of 2002.

### **2.5.3 GP and Practice Nurse education**

#### **Principles**

Before implementing any initiative in chronic disease management a needs analysis is done to determine key gaps between best evidence practice and current practice so as to focus educational activity in the areas of most importance.

GPs and Practice Nurses (PNs) are involved in the design of educational sessions.

Educational sessions are based on educational and change management principles.

Educational programmes will address clinical knowledge, practice systems and practitioner skills in proactive care, patient education and case management.

Education is done by PCO/IPAs, with secondary care specialists acting as resource people.

Wherever possible any new educational initiative will include ongoing audit and feedback in order to promote continuous quality improvement.

Wherever possible decision prompts and copies of new guidelines will be incorporated into the practitioners' PMS systems.

#### **Methodology**

##### **Educational sessions**

Meet with those responsible for providing education to the various groups e.g. clinicians, secondary care nurse educators, IPA/PCO GP and PN education facilitators and CHW trainers to plan the educational interventions.

Develop a small working group from this group who have experience in change management and provider education who will assist in the design of the educational activities.

Determine key gaps between current management and ideal management through use of audits, focus groups, key informants etc.

Determine barriers to change through use of focus groups, key informants or questionnaires.

Find the right incentives to change provider behaviour e.g. job satisfaction, more proactive care of patients, improved systems which save documentation time, better coordination between providers, incorporating the guidelines and care plans directly into software systems, financial advantages/ cost savings/ appropriate payment for services.

Design the educational activities for GPs and PNs with input from patients, providers and educators, ensuring that the most effective techniques are used.

The educational techniques which have been found to be most effective in changing behaviour are small group discussions with peers, problem based learning whereby new knowledge is applied, providing and discussing feedback data on performance, academic detailing and use of opinion leaders. Using more than one modality also increases effectiveness e.g. peer group discussion of cases, audit results and written materials. Reminders over time such as in newsletters reinforce adherence to guidelines. Follow up one on one visits to those who struggle to meet requirements may be required.

Ensure that issues such as practice systems and skills in the delivery of CCM incorporated into educational activities.

Plan to dovetail educational activities into current programmes, e.g. region wide CHW training days, clinical meetings, RMO grand rounds, quality quarterly forums, CNE meetings, GP peer review groups.

Plan to evaluate the educational activities, obtain feedback and modify if necessary. After the first time each educational programme is delivered, and at timely intervals thereafter, evaluate by obtaining feedback from both the learners and the facilitator/teachers and modify later programmes accordingly.

## **IT Support**

Determine the key process and outcome data for each chronic condition that will be entered as part of the consultation data and can be downloaded electronically for evaluation and feedback purposes.

Develop templates and decision prompts in the PMS system to encourage GPs and PNs to follow the guidelines. Also insert the guidelines into the PMS system so GPs can click through to it as a reference. Methods for doing this should be standardized so that tools for any new condition can be added at any time.

Develop systems for feeding back performance data to providers for use in educational sessions e.g. peer comparisons with opportunity for discussion and learning. As the project is implemented and data collected on adherence to guidelines, KPIs patient outcomes etc, this information can be summarised and presented to providers so they can compare their performance with that of their peers in an anonymised form and discuss reasons for variations and ways of addressing difficulties.

## 2.6. Integration with Secondary Care

### Principles

- Secondary care partnership with general practice is important in selecting target groups, scoping proposals and selecting guidelines for clinical management.
- CCM clinical guidelines form the basis of both primary and secondary care management, ensuring that care is consistent between providers.
- Secondary care clinicians and chronic care nurse specialists are an important resource for general practice team continuing education.
- Advice from secondary care clinicians for difficult management decisions is readily available to GPs.
- Advice from chronic care nurse specialists is available for practice nurses carrying out chronic care management.
- Secondary care systems (e.g. outpatient clinics, access to investigations) are rationalised to allow efficient general practice management.
- Access to secondary care for CCM patients is facilitated by systems responsive to the special needs of this group.
- Patients eligible for CCM who are first diagnosed in secondary care and do not have a general practitioner will be referred to a general practice CCM team for ongoing management, thus ensuring that 'hard to reach' patients receive regular care.
- Secondary care accepts the major responsibility for providing ongoing management for those patients with very complex or severe disease.
- Systems of communication between primary and secondary care, including referral systems, are efficient and effective.
- The number of patient points of contact in the health care system is minimised.
- The culture of secondary care is one of respect for the quality of general practice, encouraging patients to make general practice their first point of call for assistance.
- Most patients have many comorbidities and any one secondary care service will usually only address one of these, requiring the GP to provide overall coordination and management.

## **Methodology**

### **2.6.1 Planning of CCM projects**

Secondary care clinicians are involved in the policy group, the scoping group and the implementation group.

Secondary care clinicians ensure that the clinical care provided in secondary care (acute wards, outpatients and ED) is consistent with the chronic disease management guidelines adopted in general practice.

### **2.6.2 Access to secondary care services**

Facilitated access to management assistance from secondary care clinicians (medical specialists) may be provided through any of the following, with the methodology(ies) chosen depending on the nature and volume of patients:

- Efficient, timely systems for transmitting referral letters and discharge summaries
- Regular slots reserved for CCM patients in out patient clinics
- Joint secondary and general practice clinics in a general practice setting (feasible with a high volume of patients requiring secondary input)
- Virtual clinics where primary and secondary clinicians meet to discuss difficult management decisions without the patient being present
- Email/fax clinics where GPs fax or email in management problems and secondary care clinicians reply using the same communication system

Direct access to secondary care based services is facilitated by specifying necessary prerequisites for such services, and allowing for direct access where these prerequisites are met e.g. echocardiography, retinal screening, home care services.

Secondary care has a single point of entry for referrals, which are then forwarded to the appropriate service.

IPA and PMS system support for GPs and PNs ensures that when patients are referred all the appropriate general practice information is included. This support will include:

- educational support, audit and feedback
- availability of guidelines in an easily accessible format
- computerised prompting of prerequisites for direct access referrals

Where patients do not meet the prerequisites for access to certain services, but important other factors should be taken into consideration, GPs must still have the ability to refer these patients for an opinion as whether they qualify for that service.

Integration between Primary and Secondary Care may be enhanced by the introduction of chronic care nurse specialists following the model already utilized in several current integration projects. Participating with the GP and Practice Nurse in the management of patients on a CCM program these nurses will facilitate the concept of “seamless” care.

Access to secondary care for both patients and the general practice team can be facilitated by chronic care nurse specialists through the following:

- Patients in CCM programmes are entered on MMH PIMS “Alert” register so that when a patient arrives at the hospital with or without a referral
  - The patient may be seen in ED by the chronic care nurse specialist to avoid an admission or allow an enhanced early discharge
  - the appropriate clinical pathway is accessed and implemented (this decision may be difficult in patients with several medically significant conditions)
  - management, treatment and education strategies employed are consistent with those in general practice
  - The general practice team provider is advised (by email or fax)
  - The CCNS may assist with discharge planning

Patients presenting to ED with one of the listed chronic conditions but not on a CCM programme will be directed to a GP for enrolment in the programme.

- Practice Nurses participating in CCM will be assisted and supported by chronic care nurse specialists who may:
  - Provide or access specialist advice if required
  - Provide continuing education (in IPA, Primary or Secondary Care setting)
  - Provide skills and tools for care planning (in IPA or General practice setting)
  - Assist with Care Planning
  - Assist with patient education
  - Provide support with referrals
  - Provide assistance in accessing community and patient support services
  - Assist the practice nurse with post discharge home visits if necessary
  - If required to avoid hospital admission work with the practice nurse to increase services provided to the patient

### **2.6.3 Access to clinical information**

A minimum dataset on all patients in CCM is stored in a database that is accessible to other primary care providers and secondary care services 24 hours a day. This will ensure high quality care of patients when the patients own GP and their file is not accessible.

This dataset will include:

- Patient NHI
- Ethnicity
- Problem list
- Current medication list
- Allergies
- Last general practice entry onto the appropriate CCM template
- Investigation results

General practices should update the database for their patients every week day.

Patients joining the CCM will need a written explanation of what data will go where, the reasons for this, and who has access, and provide signed consent.

Data collection templates in GP PMS systems need to be GP friendly so that it is quicker and easier to use the standard templates, than not to.

In the first instance it is envisaged that there will be PMS templates with data entered in a consistent format for diabetes, chronic respiratory and cardiovascular disease.

The PMS template must be populated automatically with new data as it reaches the PMS system e.g. test results.

## **2.7. Evaluation, audit and feedback**

### **Principles**

Evaluation is done at the following levels:

Evaluation of how well each GP team is managing their patients for the purpose of providing educational feedback and support to encourage continuous quality improvement.

Evaluation of the benefits to patients and net costs of each CCM initiative for the purpose of making decisions about ongoing funding and roll out of the various initiatives.

Evaluation of the processes of the generic CCM programme for the purpose of making changes to general practice CCM systems as required.

### **2.7.1 Evaluation of general practice care**

The key purpose of ongoing evaluation of disease management at the general practice level is to determine where the gaps in care lie so that changes can be made to address these.

For each disease included in the chronic disease management programme the key performance indicators which measure evidence based processes and patient outcomes are determined. These may include lifestyle measures (smoking, fitness) examination findings, measures of patient wellbeing, laboratory results and medications.

These KPIs are included in the PMS disease management templates either as with reminders or as compulsory fields to ensure they are completed as part of the consultation.

Appropriate incentives must be in place or using the disease management templates e.g. helpful clinical prompts, faster record taking.

KPIs are kept to a minimum to avoid GP/PN resistance.

Data collection is automatic and seamless i.e. the data collected by the GP/PN during the consultation includes that which is required for evaluation purposes.

Data collection is electronic with automatic on line downloads.

Data Analysis and reporting systems are developed to give prompt feedback to practitioners on their performance with peer comparisons, in an educational environment.

Those providers who are unable to meet the expected levels of service and KPIs, even after extra support and encouragement, will have their CCM funding withdrawn. Reports which identify the practitioner are only held by the PCOs in order to ensure that the programme is essentially educative and supportive within general practice. Collated, anonymised data is used to report to the DHB.

### **2.7.2 Cost benefit analysis of each CCM initiative**

Evaluation includes systems to gather data that measures both the outcomes and the cost of each CCM target group. This data includes:

Outcomes:

- Numbers of patients cared for
- Quality of life indicators
- Morbidity indicators
- Mortality
- Hospital admissions
- Changes in management (e.g. new medications, educational and social interventions) that are known to result in predictable changes in QoL, morbidity and mortality

Costs:

- Visits to GP/PN
- CHW networks
- Investigations
- Medications (real costs rather than costs of scripts written)
- Hospital admissions
- Out patients appointments
- Home care services
- Programme costs – management and production of materials
- IT costs

This information is collated by the CCM Implementation group and reports written for the DHB which provide information on the benefits and costs of CCM for each target group.

## 2.8 Information Systems for CCM

### 2.8.1 Requirements

- IT Systems that *support* the CCM process not *drive* it.
- Utilising PMS systems in use including use of electronic clinical records.
- Prior agreement on Data set and associated issues.
  - Content – data GP needs to manage patient, data that needs to be fed back to GPs for CQI, data for programme evaluation, clinical data for sharing with other providers.
  - Governance and ownership of data, privacy rules (requires agreement by community and providers).
  - Distribution of data technology.
  - Access to data (NB currently all data held by secondary care is accessible to DHB –and most of secondary care data is available to GPs, and also sent to them in discharge summaries.)

#### **IT should facilitate and explore methods for**

- Flagging entry criteria for targeted patients
- Decision Support
- Supporting Change in Provider behaviour
  - Prompts
  - Templates
  - Management Pathways
  - Patient support and educational material
  - Management Pathways
  - Lab Request Protocols
  - Referrals (preformatted, self populated)
  - Special Investigations/procedures
  - Special Authority requests
- Data collection and background information transfer including message standards and consistency requirements
- Billing and claims submission
- Reporting (either live, by alerts, or periodic reports) subject to governance and ownership issues
- Facilitating integration and communication between all players in CCM process
- Reducing paperwork
- Automating a process and rules around tracking patients who do not attend for the services which are paid for through the programme
- IT expression of CCM pathway should be the path of least resistance for users (making the right thing the easiest thing to do)
- PMS software vendors who are flexible and have capacity to adapt to changing needs

### **IT should create connectivity with**

- Secondary Care
- CCM Server
- Community service providers (Lab, Radiology etc) – usually via Orion/Healthlink
- Other primary care providers

### **IT should**

- be able to be built incrementally according to master plan
- assist in developing a list of KPIs for the delivery and function of CCM IT system including the server eg responsiveness, robustness, timelines
- have capacity for change
- Facilitate evaluation of CCM

### **IT in turn needs precise information on**

#### ***Process***

- Who has access to data and information
- What content each of these has – ie what filters are needed
- Where is it stored, or to whom is it delivered
- What triggers (including timing) control delivery
- The how of all this can then be decided by IT

#### ***Ownership clarification***

- Data (is this owned by the patient?)
- Information (is this owned by the population?)

## **2.8.2 General practice PMS Systems**

General practice computer systems need to include the following:

1. Patient registration to include demographics
  - Age/Sex
  - Ethnicity (with explanation of correct manner to collect and code ethnicity data)
  - NHI
  - Socioeconomic Status (CSC or NZDep 96)
  - Contact Details (address, phone, email)
2. Read coded disease registers for all chronic diseases
3. Entry criteria for target patients
4. Alert flags on CCM patient files
5. CCM templates for the most common chronic diseases (e.g. diabetes, asthma and COPD, CVD, CHF). These templates must be GP friendly so that it is quicker and easier to use the standard templates, than not to.

Templates to include:

- Consent field ( with ability to print our form for signed consent)
  - Easy ways (e.g. tick boxes) of recording data during consultation
  - Reminders of guideline content by providing for data entry on key guideline activities
  - Compulsory fields for KPIs and outcomes using standard formats (kept to a minimum to encourage cooperation)
  - Links through to the CCM guidelines (able to be regularly updated)
  - Automatic saving of information into case notes for the day
  - Automatic populating of most fields e.g. Ht, recent investigations
  - Cross population of data between templates for patients with multiple chronic diseases
  - Stable fields (i.e. once data entered, will automatically populate template when next used) as appropriate e.g. date of initial diagnosis
  - Ability to chart results for specific activities according to dates carried out e.g. HbA1c, BP, peak flow
6. Link to guidelines for other chronic diseases eg using HTML
  7. Investigations and medications entered in a way that ensures these are automatically coded (assist in national process to achieve this)
  8. Decision prompts immediately accessible – without leaving the PMS screen - during the consultation, e.g. matching NYHA class for CHF to prompt to consider prescribing spironolactone
  9. Referral guidelines i.e. electronic referral forms (with automatic populating where possible) for direct entry to specified secondary care services. These forms contain the necessary prerequisites for referral, populating these from the existing data in the templates wherever possible
  10. Patient held care plans in the PMS with automatic populating of demographic details, problem lists, medications and recalls. Saving of the plan so that it can be updated rather than redone.
  11. Educational material for patients which can be edited and printed
  12. Recall systems for appointments and reminders for investigations due
  13. Billing and claims systems for CCM services
  14. Ability to extract from PMS
    - KPIs and outcomes from templates - for peer review and education
    - KPIs, outcomes and key services provided (e.g. production of patient held care plans, number of visits for each disease), medications (NB costs of prescribed vs dispensed vs taken) and investigations in a way that can be costed - for CCM project evaluation

- CCM clinical subset: NHI, demographics, problem list, current medications, allergies, latest investigations, specified data from template to CCM server for access by other providers

### **2.8.3 System and data requirements from secondary care**

For CCM patients the following will need to be collected in order to assess costs

- Admissions and length of stay
- OP clinic appointments
- ED visits
- Chronic care nurse specialists
- Other services e.g. investigations, home help
- Costs for each of the above

The clinical requirements in secondary care for IT are as follows:

- Alerts in secondary IT systems that patient is CCM pt
- Ability to feed into CCM server for CCM clinical subset and update it so that the CCM clinical subset is continually updated and accessible to other secondary and primary care providers
- A process to ensure that lab tests in both primary and secondary care are transferable from one to the other and readable by both
- Links to clinical pathways (and guidelines – covered above)
- Discharge and OP clinic summaries including management plan
- Performance against specified KPIs and outcomes

### **2.8.4 Data flows**

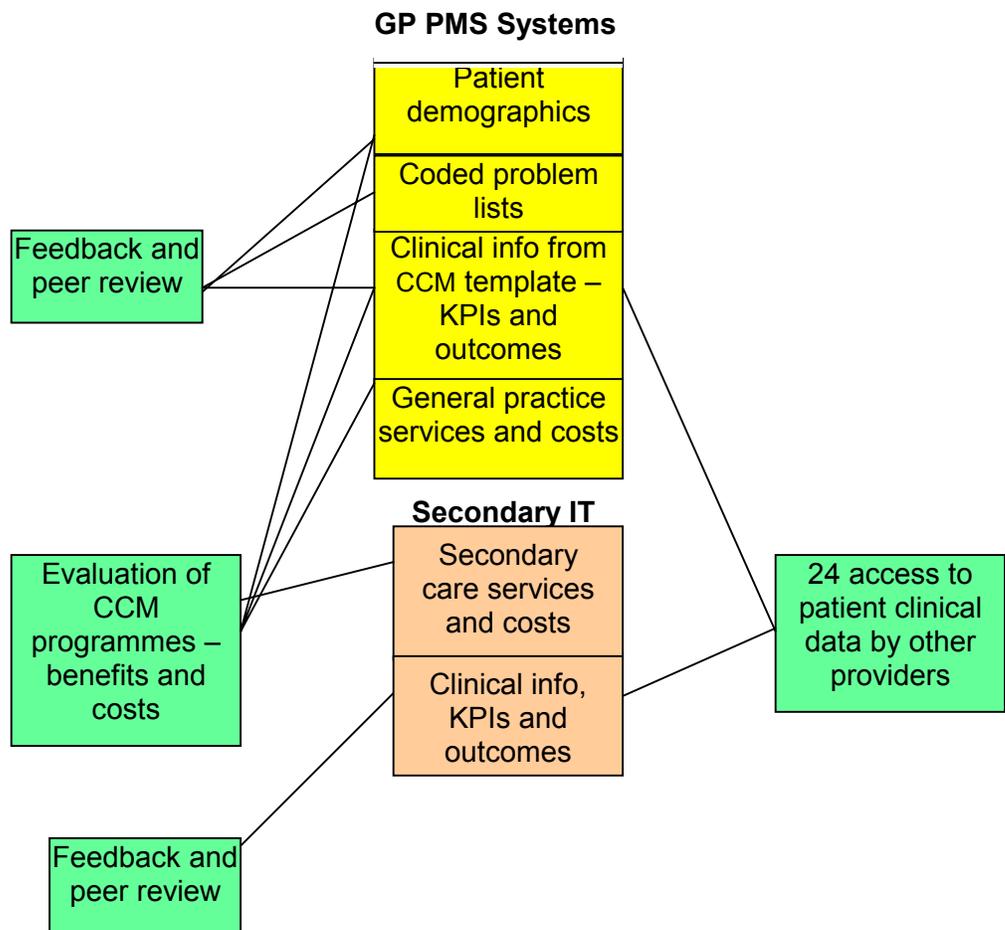
- Clinical data (KPIs and outcomes) from PMS to PCO for GP education and peer review
- Demographic, aggregated clinical (KPIs and outcomes) and cost data from PMS to CCM implementation group for evaluation
- Utilisation and cost data from secondary care to CCM implementation group for evaluation
- Clinical data from secondary care to secondary educators
- Clinical and demographic data to other appropriate providers all hours

A model of the data flows is shown on the following page.

Rules around data flow, storage and access to the various levels of information e.g. patient clinical data and GP/PN performance data, need to be developed and signed off by all stakeholders. This is the task of the Governance Group ( Section 3.2).

Collection and analysis of this data will allow ongoing assessment of the cost per targeted patient of the various CCM programmes, along with the resulting improvements in care, health outcomes and health status. This will show which patients are benefiting most from CCM and enable decisions to be made regarding more effective selection of patients (See sections 2.1, 2.7).

**Model for the Collection and transmission of CCM data**

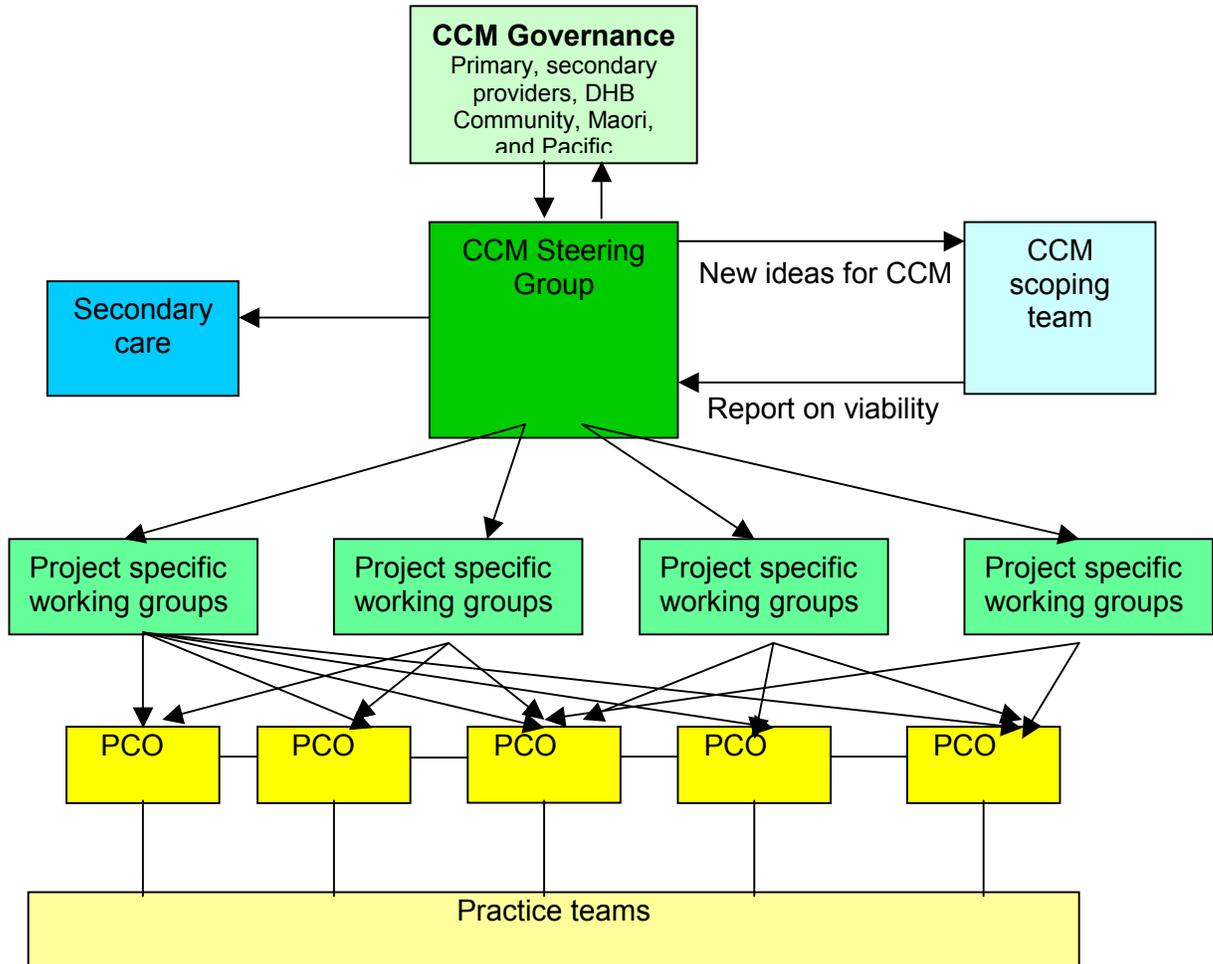


### 3. Governance and management structure for CCM

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#### 3.1 Model

The overall governance and management structure required for the implementation of a generic system of CCM across primary and secondary care is shown in the following diagram:



### **3.2 Governance group**

A governance group is required both to ensure buy in from secondary and general practice clinicians and to provide overall governance to the process in a way that ensures accountability and adherence to the key principles of chronic care management as outlined in the plan.

It may be that an existing group can take on this function for CCM, or a subgroup of an existing body be formed to carry out these functions, such as a subgroup of the Community and Public Health Advisory Committee. It is important that the nature and membership of the governance group be acceptable to all parties involved.

**Structure:** Partnership model between general practice, secondary care the funder and the community.

#### **Objectives/ tasks**

To provide vision and strategic direction for all CCM projects through:

1. Endorsing the CCM model and plan for implementation (after modifications if necessary)
2. Taking responsibility for ongoing changes to policy and the generic plan as required
3. Setting policy and rules regarding data eg information flow, who has access, filtering mechanisms
4. Making recommendations to the DHB as to which CCM projects should be funded
5. Receiving reports on the success of each CCM project
6. Exploring how funding for, for CCM, can be merged with the new capitation formula and into general contracting requirements
7. Ensure that the incentives and disincentives for general practice teams to be involved are monitored and addressed
8. Consulting with others as required

#### **Issues**

The governance group is the representative of the funders ie DHB, general practice care and patient.

Secondary care clinicians are also included because of their important role.

General practice needs to have enough comfort to be involved and contribute resources and data (there is a track record of funders reacting to general practice audit data by funding new providers and fragmenting care rather than assisting general practice to improve).

This structure acknowledges that both patients and general practice are contributing resources that are separate to DHB funding and that whereas the DHB owns secondary care, it does not own general practice.

Community input is included and Maori and Pacific patients' needs are represented.

## **Membership**

The suggested membership is as follows:

- 2 primary clinicians nominated by general practice
- 2 secondary clinicians nominate from SAH
- 3 community representatives, including Maori and Pacific
- 2 DHB representatives

The above people should be appointed because of their skills in strategic thinking, policy setting, ability to work with others in a team, and their understanding of chronic care management and health systems.

### **3.3 CCM Steering Group**

The CCM Steering Group will operate at the strategic and operational level to:

1. Oversee the development of the infrastructure required for CCM, i.e.:
  - Practice structures
  - IPA/PCO support systems
  - IT systems
  - Generic educational materials for providers and patients
  - CHW pilot
  - Cultural competence requirements and educational programmes

It is envisaged that in the first five years funding will need to go into contracting practices, PCOs, IT systems educationalists, to develop the infrastructure required for CCM.

2. Provide management oversight for the implementation and evaluation of each CCM project.
3. Receive suggestions for CCM projects from other parties, prioritise these suggestions, define the questions that need to be asked in the scoping process and then commission this work from the scoping group.
4. Make recommendations through the governance group for the funding of projects.
5. Make recommendations to the governance group regarding required changes in policies and the generic plan as the need arises. The recommendations would be expected to outline the size of the effect of the proposed CCM initiative and the marginal costs of achieving this benefit.
6. Provide reports to the governance group on the outcomes of funded projects.

A full time Manager and PA will be appointed whose role it will be to implement the above tasks under the guidance of the CCM Steering Group.

Each CCM project will have a working group made up of some members from the CCM Steering Group and some members who are specific to that project. Each working group will be part of the CCM Steering Group but will only attend for those parts of the meeting which pertain to their project.

Suggestions for CCM projects will come from sources that include:

- primary and secondary care clinicians
- analyses of primary and secondary care morbidity and mortality data
- community advocacy groups
- general practice
- DHB
- Ministry of Health
- national and regional health goals

### **Membership of the CCM Steering Group**

- Clinical GP
- Practice nurse
- IPA/PCO manager
- IT person
- Person skilled in change management for providers and patients
- Secondary care clinician
- Secondary care manager
- DHB integration person
- Maori
- Pacific
- CCM Manager

### **3.4 Scoping team**

An in depth scoping process is of major importance in ensuring that new interventions are appropriate and health dollars spent wisely. The scoping team will carry out both a needs analysis and a financial analysis (See Section 2.1). Members of this team will be convened on an ad hoc basis and may come from a variety of organisations, or the task may be contracted out to those with the skills, depending on the nature of the proposed target group and intervention. Types of analysis will vary depending on the situation, proposed target group, and suggested intervention. This process is expected to take three months for each area scoped.

It is expected that those carrying out the scoping will have the following skills:

- Epidemiology
- Financial analysis
- IT systems
- Clinical and critical appraisal skills
- Maori perspective
- Pacific perspective
- Community perspective including other cultural groups as required

### **3.5 Project working groups**

Each project will have a key working group for day to day operational management of the project made up of:

- Project manager (approximately 2/10 per CCM project)
- 2 clinical advisors (from primary and secondary care, who may or may not be members of the CCM Steering Group)
- One other as required

It is expected that the project manager and one other member of the working group will also be members of the CCM Steering Group to ensure that work done at the generic level is rolled out in each project.

With the guidance of this group and assistance of the CCM Manager the project manager will roll out the project according to the generic plan, and generic structures and systems put in place in primary and secondary care for CCM, including the requirements for cultural competence. The project manager will work with the PCO/IPA facilitators to implement the projects, rather than dealing directly with providers themselves.

### **3.6 PCOs/IPAs/ Practice collectives**

Each PCO/IPA will be expected to have in place a CCM Facilitator who will work with each project working group to implement all projects with the practice teams in their organisation. This will include education regarding guidelines, assistance with developing practice processes for CCM including team development, assistance with translating guidelines into flowplans, collecting, analysing and reporting on KPIs, and providing feedback and peer comparisons.

These activities are funded by the project, and may link in with other similar activities already being carried out by the IPA/PCO s to assist practices with their management systems, practice structures and IT systems.

Where GPs do not belong to an IPA or PCO they may form collectives and contract these functions to other organisations or employ someone to assist with these tasks.

### **3.7 Practice teams**

The incentives for practices to take on board CCM are as follows:

- improved job satisfaction through having paid time to provide more thorough proactive and preventive care
- assistance from their IPA/PCO to set up the practice systems and structures required for CCM (See section 2.4)

- payment to the practice each year to develop and maintain CCM practice systems (methods for applying this payment to be determined, with one possibility that half be paid up front and half when it can be demonstrated that the required systems are in place)
- lump sum per patient in the programme to provide a number of specified services and report on selected KPIs and patient outcomes. It is expected that each CCM patient will receive four free consultations from their GP and up to 12 half hour educational assessments from their PN (this is an average figure with higher risk patients receiving more services and lower risk patients, receiving less). In addition some patients will require support from a CHW. There will be some flexibility as to how the practice provides these services as to how this is applied as long as data is transmitted on the services provided, KPIs and outcomes. (With time as data is collected and a better understanding is obtained as to what level of KPIs can be expected full payment may be dependent on how well the KPIs have been met, with allowance for differing practice population demographics)
- ongoing CME and audit in topics related to common chronic diseases
- assistance to work as a team, enhancing the role of all members

Many disincentives are in operation that the above incentives will need to overcome. It is important that the programme monitors and modifies the incentives and disincentives appropriately for continued general practice involvement.

### **3.8 Secondary Care**

This document makes suggestions for the interface between primary and secondary care and for IT requirements within secondary care, but does not include policy or structures.

## **4. Implementation plan**

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The following steps are required in order to operationalise the plan:

### **Setting up the structures required for governance and management**

1. General Manager Integration Care coordinates the formation of the governance group (see Section 3.2) and arranges the first meeting within one month.
2. Governance group endorses the policies within the document (with changes as required)
3. Governance group takes the IT requirements and decides how the functionality required can best be achieved, i.e. where data will be stored, who will have access, what types of reports will go to whom, and write the rules governing this (see section 2.8).
4. Manager of CCM Steering Group is appointed within one month (See section 3.3) and moves quickly to develop step 6 onwards of this implementation plan into a detailed operational plan with responsibilities and timelines.
5. Members of CCM Steering Group (see Section 3.3) appointed within two months.

### **Development of generic CCM processes**

6. Current DM project leaders become Project Managers in each Working group, answerable to the CCM Steering Group (See Section 3.5).
7. CCM manager works with project managers to move all projects towards the generic plan, using generic tools and systems across all projects. (See Sections 2.5-8 for more details).
8. CCM manager works with Maori and Pacific to implement the cultural competency requirements for CCM, piloting initiatives as they are developed. (See Section 2.2)
9. CCM Manager works with DHB IT team to implement, in a step wise fashion, the IT requirements for CCM. (See Section 2.8)
10. IT requirements should focus first on setting up CCM templates and other requirements within PMS systems, including the ability to download KPIs and services for audit, feedback and evaluation purposes. Shared clinical database on CCM patients is implemented at the next stage. (See section 2.8).
11. The COPD and COPD/Asthma projects will be amalgamated into one project over the course of the year including adoption of the patient empowerment tools of the COPD/Asthma project.

### **Targeting of patient groups**

12. Over the five years data collected on the cost effectiveness of providing CCM to each target group will be continually analysed and decisions made on an ongoing basis by the CCM Steering group as to whether to change the target group specifications accordingly (See sections 2.1,2.7, 2.8)
13. It is expected that over the five years the number of target groups will increase from the current three (diabetes, CHF, asthma/COPD) to six.
14. CCM patients may have anything from one to all of the targeted conditions, each being managed according to the guidelines for those conditions they have.
15. New target groups will be added based on the recommendations of the CCM Steering group after thorough scoping of any ideas by the Scoping Group. The first two suggestions for the scoping group are CVD and gout. CVD may need to be divided into early management of those with risk factors and management of those with established disease.
16. Scoping team members will be appointed from among current DHB, SAH and IPA/PCO staff, or the required tasks may be contracted out to other individuals or organisations.

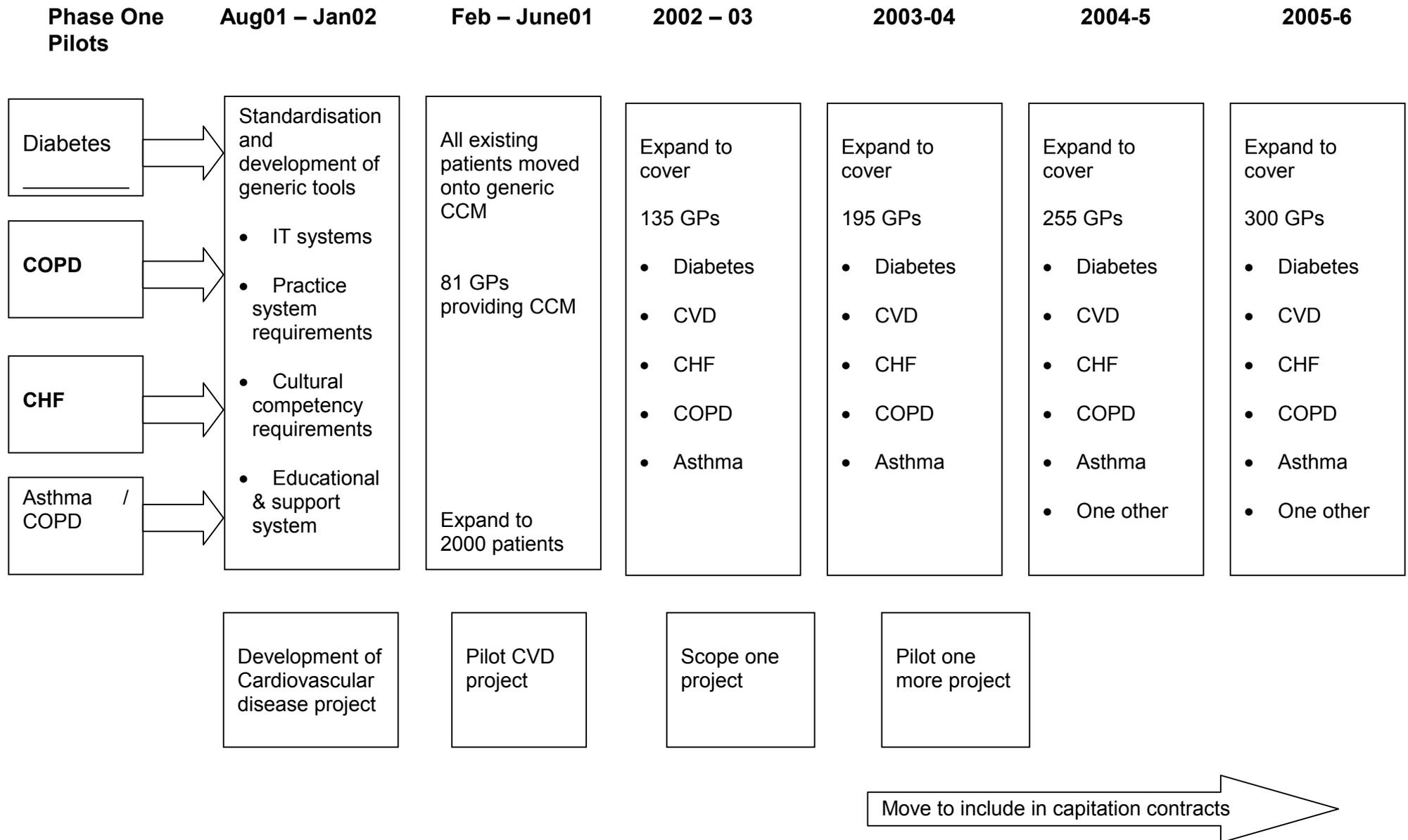
### **General practice activities**

17. Those general practices already involved in DM projects will be invited to join the project in the first year, aiming for 27 general practices i.e. 81 GPs and their staff.
18. In this first year these practices will offer CCM to patients meeting the target criteria for any of the current DM projects, increasing the number of patients enrolled to 25 per GP. This number is a guide for budgeting purposes and to provide enough incentive to the practice to change the systems required e.g. employ new staff. Some GPs may have capacity for more than 25 patients and some less. The CCM Steering Group will provide advice to practices on how to prioritise which patients are included if they have more than 25 who meet the target group requirements
19. By the end of the five years each GP will be expected to have 75 patients enrolled in CCM.
20. Practices will be paid on a per patient basis to provide a number of specified services, and report on selected KPIs. It is expected that each CCM patient on average will receive four free consultations from their GP and 12 free half hour educational assessments by their PN. In addition some patients will require education from a CHW. Payment per patient may vary according to severity of disease and effort required to assist the patient to manage their health (i.e. more for the hard to reach patient).

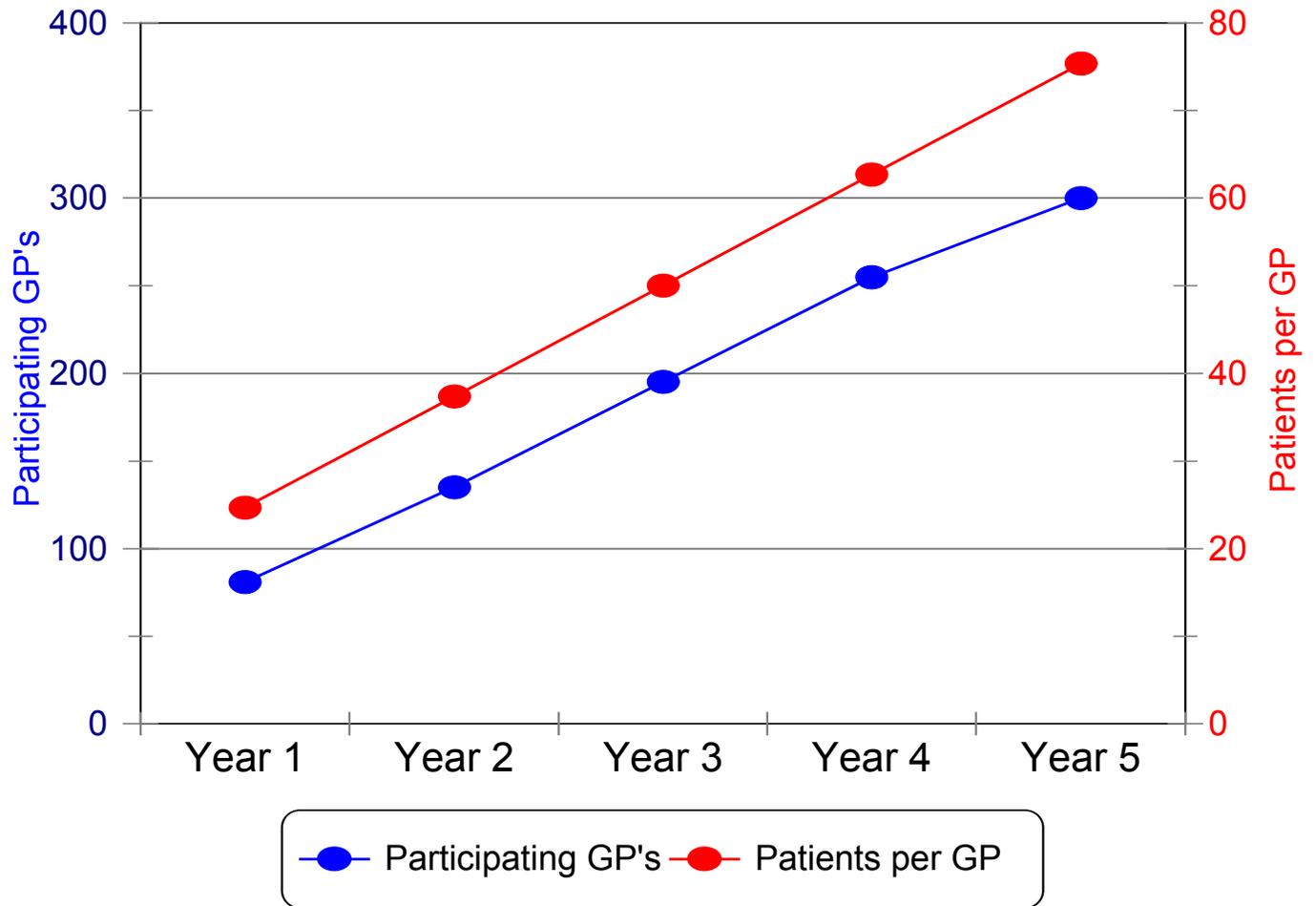
21. For recruiting and managing the required number of patients per year practices will also be paid a lump sum per GP to cover education and practice management activities to support the programme. During the first year in the programme practice will be expected to use this assistance to bring their practice to the standard laid out in Section 2.4 e.g. Read coded registers, accurate ethnicity recording, appointment of one team to manage the CCM within the practice.
22. IPAs/PCOs or equivalent groupings will be paid to support the practices both in helping them develop the practice systems and structures required for CCM and also in arranging the educational and audit sessions and ensuring that data is collected and transferred as required. The payment will be based on the number of GPs they have involved in CCM. Unaligned practices may group together to arrange these services or contract them from other groups.
23. Each year for the next five years more practices will be brought on board in an incremental fashion until by the fifth year all practices will be able to be involved. Any practice may volunteer to be involved, regardless of their IPA or PCO affiliation or lack thereof. If there are more volunteer practices than the budget allows for, those who have most closely met the practice systems requirements in section 2.4 will be given precedence.
24. The new practices brought on each year will have assistance to develop their practice systems and structures, an introduction to CCM, educational sessions on how to manage each target group included in the CCM program and assistance to design patient flow plans for each target group.
25. Each year existing practices will continue with patients already enrolled, add new patients within the specified numbers, add in CCM for new target groups, including existing CCM patients who also meet new target group requirements. They will be involved in ongoing audit and feedback for all CCM projects.
26. Practices that do not meet the expected KPIs and outcomes will receive extra assistance and support. However lack of response to this assistance will result in CCM funding being withdrawn from these practices.



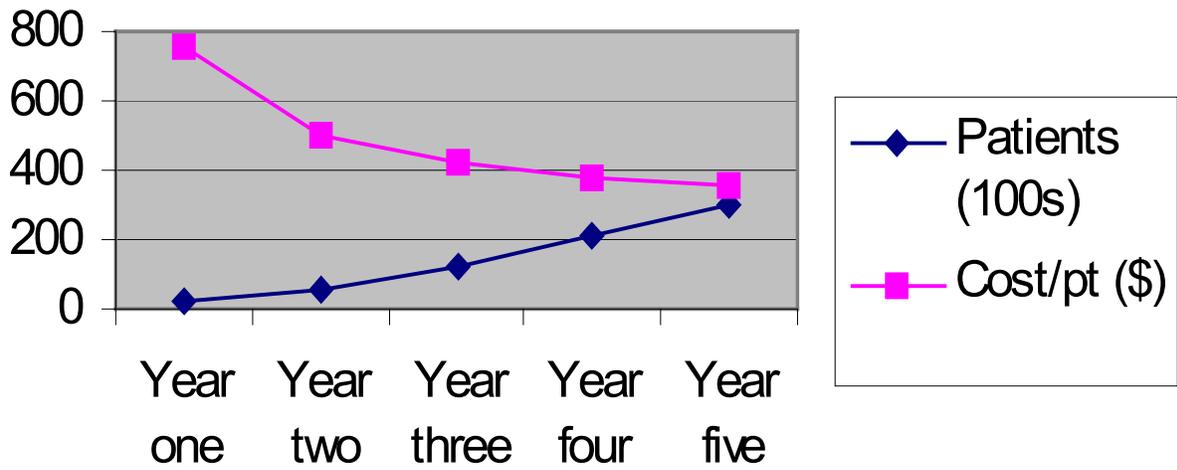
# Summary of Implementation Plan



# Chronic Care Management



## Numbers of patients and costs



## **5. Budget and ROI**

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### **5.1 Notes on budget**

The budget has been set for five years

It allows for an increasing number of patients and increasing number of GPs and practices to be included in the project each year

Costs per patient decrease as the number of patients included per GP increase, since system costs remain almost constant.

The first table is an overview, the following 2 tables provide more detail.

#### **5.1.1 CCM Management**

##### **Governance group**

This group of nine people is expected to meet for two hours eleven times a year, with payments made at the rate of \$100 per hour. Secretarial support is allowed for.

##### **IT**

A budget already exists for IT expenditure

##### **CCM Steering Group**

This group of ten people is budgeted to meet for four hours eleven times a year

There is funding for a full time manager and full time PA.

There is one CCM Steering Group for all CCM projects.

##### **Scoping Group**

It is expected that up to five people will need to work 20 hours a month for 3 months to provide he needs analysis and financial analysis for each new CCM suggestion approved by the CCM Steering Group. These people are expected to be current employees of the DHB, SAH or IPAs with their employers compensated for their time at the rate of \$50 per hour.

Funding is allowed for two new suggestions to be scoped each year.

##### **Project working groups**

Three people are budgeted for each group, at four hours per month, in addition to the Project Manager who is budgeted for at 2/10.

There is one project working group for each CCM project or patient target group.

#### **5.1.2 Project level**

##### **Funding per enrolled patient**

There is funding to cover the cost of four visits to the GP per year, at \$40 per visit, and assuming the patient has either a CSC or HUC. This is for an average level of intervention. For some diagnoses there may be different levels of intervention according to the severity of disease or other patient factors.

Some patients will need the assistance of a CHW; it is estimated that for every 500 patients in the project, one CHW will be available for those who need referral. It is preferable that a number of CHWs be employed to cover the common Pacific languages. The Maori Disease management nurses are also available.

It is expected that the practice nurse will spend 30 minutes with each patient twelve times a year. Only 27% of nurse time is currently funded by Vote Health.

A proportion of patients will see secondary care physicians and nurses. This is budgeted but not included as a cost to CCM.

It is acknowledged that project may either decrease or increase costs of pharmaceuticals or investigations. Since this cost varies according to the patient group and is currently funded by S88 costings have not been included.

Each patient will receive a generic patient held care plan and other educational materials.

### **Funding per practice**

Funding has been calculated on an average practice size of three FTE GPs, with smaller practices expected to share funding and larger practices receiving extra accordingly.

A cultural competence workshop has been allowed for with this part funded by the IPAs/PCOs since the learning will also be applied to other patients and these groups already have a responsibility for improving Maori and Pacific health . It is expected that this will be an annual cost given the cultural diversity of South Auckland and the need for this to be a continuous improvement process.

Staff training in CCM processes allows for two hours per year for 3 GPs (\$50 per hour), four hours for 2 PNs (\$25 per hour) and four hours for one other staff member (\$25 per hour).

IT connectivity and maintenance will be required; these costs are already covered by the practices.

Time allowed for audit, feedback, change, and CME of practice staff is triple that allowed for CCM processes.

Funding is also allowed for practice meetings and put in place practice implementation plans for each project.

It is expected that the practice will allocate the management of each CCM project to one person taking one hour per week at \$25 per hour for each of four projects.

The practice management cost of \$8900 will cover the practice supporting structures and systems for a total of 75 patients per year in the first year (\$119 per patient), with the cost remaining the same as the practice increases to six projects and 300 patients over 5 years (\$30 per patient). This frontloading reflects the extra costs in establishing systems at the beginning of the project.

### **IPA/PCO support**

For every nine GPs providing CCM an IPA/PCO facilitator will be required to provide a number of services. These are estimated per CCM project

Education and audit regarding guidelines will require two hours per week of preparation and provision of educational sessions at \$50 per hour.

Collecting, analysing and reporting on KPIs is expected to take 50 hours per year.

Translating guideline into practice flowplans is expected to take four hours for each of three practices per project.

Training Staff members in practice systems takes three hours per practice per month.

The hours calculated for this are double to allow for overheads and administration time. IPA/PCO support is frontloaded at \$77 per patient, decreasing to \$17 per patient per project over five years.