

Health Information Strategy for New Zealand

HISAC, THE HEALTH INFORMATION STRATEGY ACTION COMMITTEE

Action Zone 7 - Chronic Care and Disease Management

An Initial View

This document is an initial HISAC view of the 'Chronic Care and Disease Management' Action Zone of the *Health Information Strategy for New Zealand 2005 (HIS-NZ)*. Its purpose is to stimulate discussion and responses from health and disability sector practitioners, providers and funders, about the issues and opportunities associated with the improved use of existing and emerging information technologies and information management systems in the health and disability sector.

This Initial View is a HISAC informed 'Straw Man' and it does not claim to represent the final direction of the Action Zone. The Initial View is a starting point for the sector informed Preliminary Scope and Approach currently being prepared, by proactive engagement with the sector, for each Action Zone.

If you have a view on the ideas presented below, HISAC wants to hear from you.

This Initial View focuses on the identification and management of patients and populations at high risk, or with chronic conditions. Information may also be generated to support preventative approaches to chronic conditions.

Improvement in the management of chronic disease will be achieved through improved information sharing with all providers including relevant NGOs. However, the focus will be on interoperability between the primary and secondary sectors, especially in the management of cardiovascular disease (CVD) and diabetes.

HISAC sees Chronic Care and Disease Management being delivered through a combination of standards, improved access to information that supports quality improvement activities and the deployment of shared relevant patient information. The development of actual care delivery models or programmes is out of scope.

A VIEW OF CHRONIC CARE AND DISEASE MANAGEMENT IN THE FUTURE

VISION:

Reliably identify and manage individuals and populations at high risk of developing, or with, chronic conditions.

STRATEGY:

Implement sector-wide information management to support the identification and management of people and populations at high risk, and those with high priority chronic conditions.

DESCRIPTION OF CHRONIC CARE AND DISEASE MANAGEMENT

A snapshot of HISAC's view of Action Zone 10 Primary Care Information is shown below as informed by HIS-NZ, the Primary Health Care Strategy, and by some current sector thinking.

HISAC anticipates that improved Chronic Care and

Disease Management will be based upon:

- Interoperability and standards so information can be easily shared for clinical decision making and treatment planning (e.g. through standardised coding of health events, medications, and clinical data).
- Clinical decision support (e.g. improved access to CVD risk assessment and advice and/or workflow reminders to support co-ordination).
- Better analysis and risk assessment of enrolled populations.
- Better understanding of, and access to, information tools that support quality improvement activities.

FEATURES OF CHRONIC CARE AND DISEASE MANAGEMENT

HISAC envisages that improved Chronic Care and Disease Management may include these features:

1. High risk populations are proactively identified and managed.
2. Evidence-based guidelines and health indicators assist decision making at all levels; clinical, service, and policy.

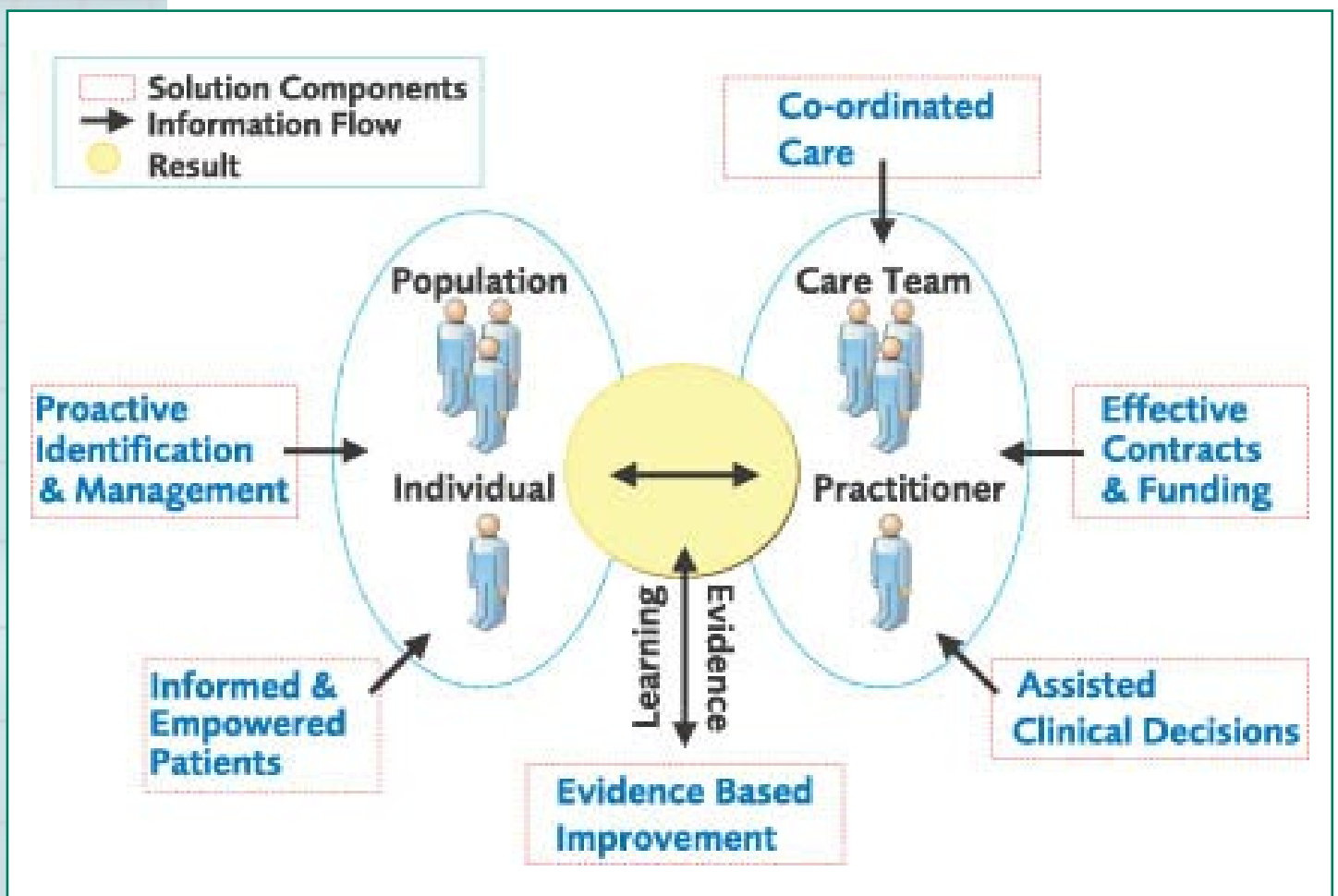


Figure 1: A Model of the Future Chronic Care Information Environment

3. Key pieces of information are shared and treatment is co-ordinated:
 - a. Workflow and care plans support care co-ordination by multiple providers;
 - b. Clinical results support treatment and management decisions as well as the efficient use of resources.
4. Data accuracy is achieved by ensuring data is captured at the point-of-care and flows through to groups that actually use and value it.
5. The focus is on high priority conditions and, in particular, diabetes and cardiovascular disease.

BENEFITS

Patients and people in care will benefit from an improved Chronic Care and Disease Management information environment by:

- Receiving consistent clinical advice and treatment.
- Having better access to information to help self management.

Health practitioners will benefit from an improved Chronic Care and Disease Management information environment through:

- Improved care planning and clinical indicators to enable better treatment management choices.
- Improved access to evidence based clinical advice.
- Improved feedback to identify areas of good performance and areas for potential quality improvement.

Organisations that fund the health and disability sector will benefit from an improved Chronic Care and Disease Management information environment through:

- Improved feedback on practitioner and system performance as it relates to both health improvement and impacts on inequalities.
- Reduced costs of managing chronic illness in secondary care.

Organisations responsible for delivery of health and care results that support population-based strategies will benefit from an improved Chronic Care and Disease Management information environment through:

- Improved feedback on system performance and areas of focus for future policy development.

WHAT HAPPENS TODAY?

Chronic Care and Disease Management in New Zealand is characterised by a variety of approaches employed across the country. Supporting information systems include:

- Those simply automating and capturing information about a disease programme locally.
- More complex systems sharing clinical and key event information across multiple providers.

None are at the stage where they are able to orchestrate and direct care across multiple providers.

Chronic Care and Disease Management is not currently addressed by one system or process (compared with, say, laboratory test ordering and results). Instead there are a variety of approaches. Some programmes focus more on patient identification through screening (e.g. HealthWest), whereas others focus more on the management of patients with particular diseases and complications (e.g. Counties Manukau). Some focus on case management through secondary based outreach (e.g. Capital & Coast and Canterbury), whereas others are community or primary care based (e.g. Get Checked).

As a result the sector is currently employing a variety of information systems to support these various programmes. A significant challenge is the low level of interoperability and information sharing between these various systems and those with no or limited capability.

AREAS FOR IMPROVEMENT

HISAC has identified the following areas where strengthening information systems and processes could deliver benefits in Chronic Care and Disease Management:

1. That simple cost effective interventions are not happening dependably for patients with chronic conditions. Information systems can support this through consistent decision support and feedback on treatment gaps.
2. That there is a relatively low level of co-ordination and information sharing between practitioners. Information systems can support this through improved referral processes and information sharing.
3. That there is limited programme level feedback on clinical indicators and population health management as it relates to chronic conditions. Information systems can support this through improved reporting and feedback at all levels of the sector.

Taking the priority conditions of diabetes and cardiovascular disease as a case study, the areas for improvement are:

1. **Patient Identification:** It is difficult for most providers to screen and identify patients as they

don't have good access to electronic risk assessment tools, or reporting tools to know who they have screened, and who they are yet to screen.

2. **Clinical Decision Support:** Different organisations are working to different guidelines and protocols. Electronically consistent advice is only available from one vendor, with relatively high access costs and limited integration with other vendors (especially secondary). In addition, laboratory results are often confined to those directly requested by that practitioner rather than including those requested by others e.g. primary care being unable to easily access and codify secondary care results and interventions.
3. **Patient Self Management:** Patient information is held in disparate locations which are not easily located by practitioners or patients. Patients themselves do not have good access to their own clinical record and test results. In addition, it is difficult for practitioners to reinforce patient goals as they are not readily shared between multiple treating practitioners.
4. **Programme Administration and Transaction Processing:** Funding arrangements, at least in the primary care setting, often require labour intensive manual reconciliation processes. Mechanisms to communicate key pieces of clinical and administrative information are often inefficient or absent.
5. **Workflow & Co-ordination:** As few as 30% of all patients partake in cardiac rehabilitation programmes who should. In addition, secondary services, community providers and primary care are often unaware of interventions being employed by each other and vice versa.
6. **Reporting and Systems Feedback:** There is some reporting and feedback with programmes such as Get Checked but low levels of feedback on outcomes and potential treatment gaps at the practitioner level. In addition, information is difficult to access to review service design, and for policy development and research.

WHAT HAPPENS NEXT?

Responsibility for implementing the Health Information Strategy for New Zealand lies with the whole health and disability sector under the leadership of HISAC. HISAC is working closely with sector representatives to prepare more detailed descriptions of the current problems and health practitioners' priorities for improvements. If you have any ideas of how the Chronic Care and Disease Management initiative could be developed, please communicate with HISAC through enquiries@hisac.govt.nz or write to:

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