

Systems Of Care:

“A Cure for the Clutter?”

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Senior Manager – Design & Development
7th December 2009



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- ▶ Who or What is ProCare?
- ▶ Contextual Environment
- ▶ Systems of Care
 - ▶ Continuous Care
 - ▶ Episodic care and virtual budget management
- ▶ Patient/Community Empowerment
- ▶ A Patient's Journey



What is ProCare?



ProCare at a Glance



Enrolled Population
670,987
(50% of Aucklanders)

- High Needs**
- 59,424 Maori
 - 72,894 Pacific
 - 49,459 Other

**Population Health Through
3 PHOs**

**Management Services To
Primary Care**

Primary Care Provider

**Support For Organised
General Practice**

- General Practices**
- 580 GPs
 - 450 Practice Nurses

- Other Contractors**
- Pharmacy
 - Radiology
 - Allied Health Prof.



Two Critical Relationships

The success of general practice depends (mostly) on the relationship they have with their patients – our job is to add value to that relationship



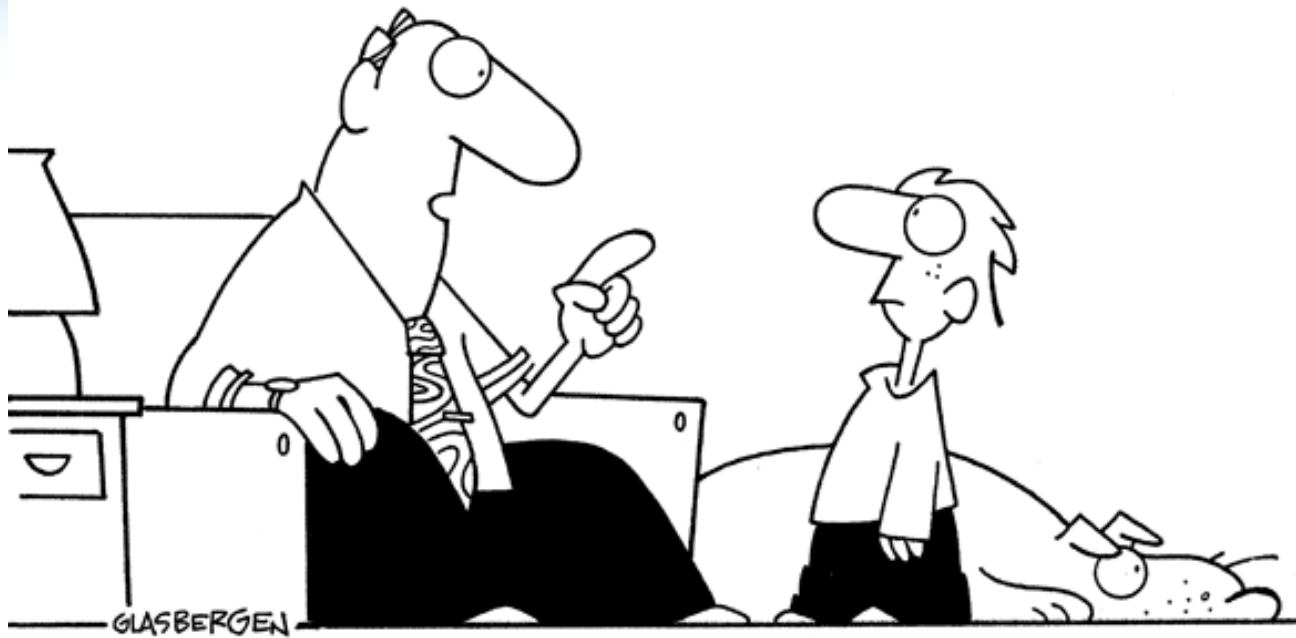
The success of ProCare depends on the loyalty of our practices, which in turn depends on the value we contribute to those practices



60% of ProCare's staff provide patient care coordinated through practices & 15% directly support practices.



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www.glasbergen.com



***“It’s not what you know that matters or who you know.
It’s what you know about who you know!”***



Changes for practice teams through the development of PHOs

- ▶ Patient Enrolment – provides a population ‘denominator’ - NHI
- ▶ Mixed Capitation / Fee for Service Funding:
 - ▶ *(ability to set co-payments)*
 - ▶ “Services to Improve Access” Funding (SIA)
 - ▶ “Very Low Cost Access” scheme
- ▶ Increasing Workforce diversification



The clumsy path to “Systems of Care”



OUR FIRST CHRONIC CARE MANAGEMENT PROGRAMME : COPD

- ▶ Why COPD?
- ▶ 9% per annum increase in acute medical admissions to Hospital was limiting ability to provide Elective Services.
- ▶ Willing Secondary Care Partners
- ▶ Significant volume of patients (Est. > 2,000 per annum)



OBJECTIVES OF COPD

- ▶ Improve health outcomes for patients
- ▶ Reduce acute burden on hospitals
- ▶ Create a 'sustainable' and 'scalable' primary care based solution

- ▶ (Not exactly rocket science...)



COMPONENTS OF OUR COPD CHRONIC DISEASE MANAGEMENT PROGRAMME

Green Prescription Exercise Programme

Pulmonary Rehabilitation Courses

Smoking Cessation Programme

Patient Held Wellness Plan

Free GP Visits

Spirometry in General Practice

Pneumococcal Vaccination

Case Management in General Practice

Specialist Nurse Support

COPD Management Guideline

"Magic" Patient Support Group



COPD RESULTS

RCT of Case Management by General Practice in Moderate to Severe COPD

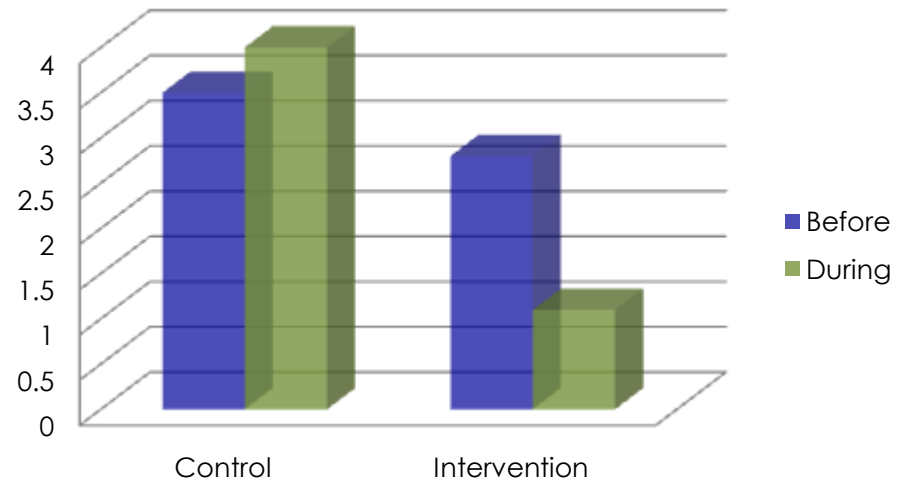
Statistically Significant improvements ($p < 0.05$) seen in:

- FEV 1 (Actual & % Predicted)
- CRQ Mastery and Fatigue Dimensions
- Mean Respiratory Bed Days

Trends to Improvement seen in:

- Shuttle Walk Distance
- All Cause Hospital Bed Days
- CRQ Emotional Function Dimension

Mean Respiratory Hospital Bed Days

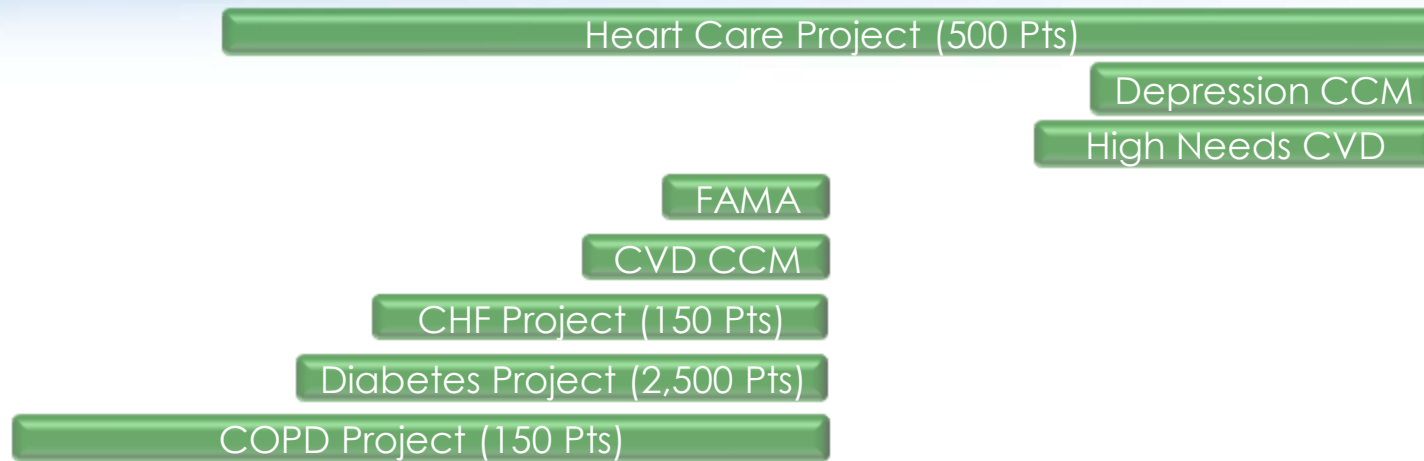


A chronic disease management programme can reduce days in hospital for patients with COPD

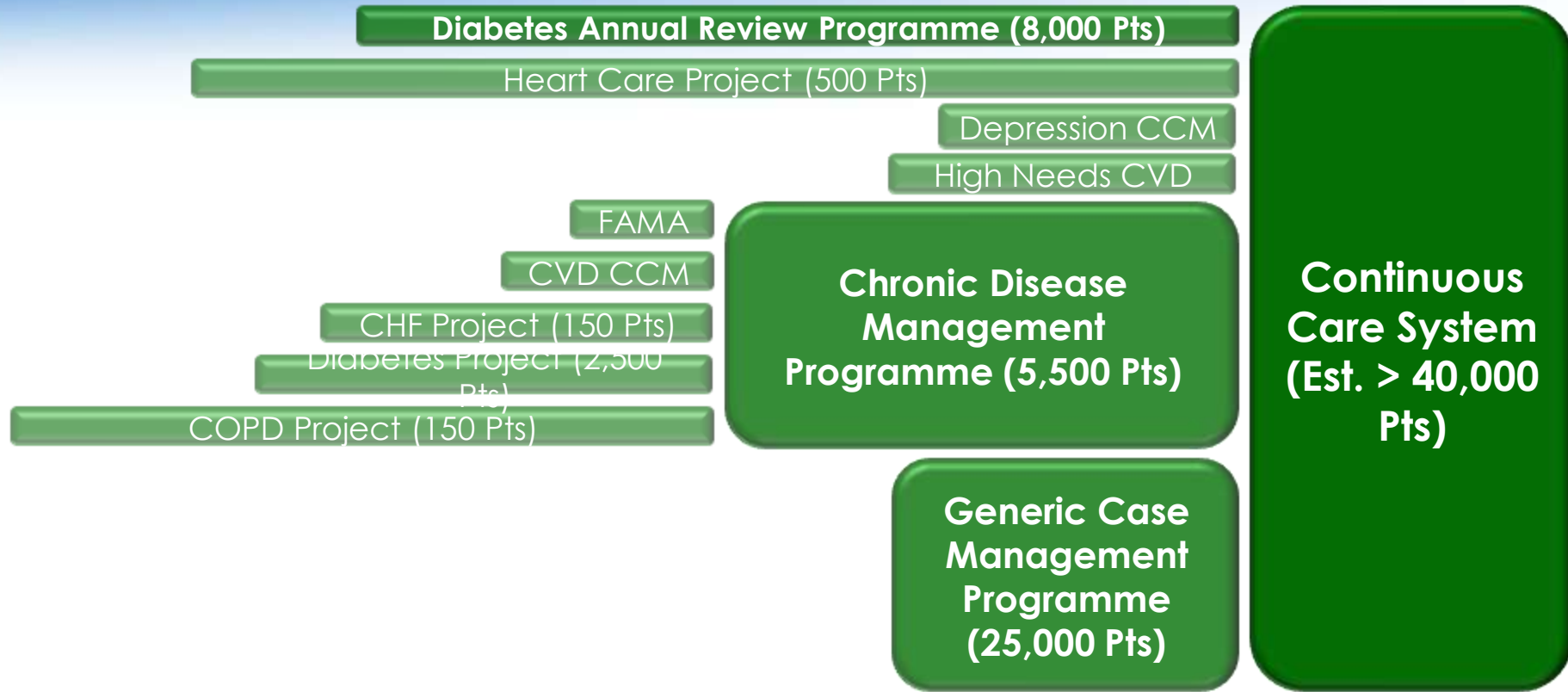
Rea H, McAuley S, Stewart A, Didsbury P, Lamont C, Roseman P. Internal Medicine Journal 2004; 34: 608-614



PROJECTS TO PROGRAMMES TO SYSTEMS IN CHRONIC CARE



PROJECTS TO PROGRAMMES TO SYSTEMS IN CHRONIC CARE



1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009



MeNZB

CVD Screening

Care Plus

Back2Action

U25

Spirometry

Beta Blocker Initiation

Engage

Cervical Screening

CCM Boost

Diabetes Get Checked

Choose 2 B Free

Electronic Clinical Decision Support

Diabetes Incentives

Medication reviews

CCM Depression

Self Management

CCM CVD

PPS

FAMA

CCM Diabetes

Peer review

CCM CHF

ECG

POAC

Insulin Initiation

Community Health Coordinators

Minor Surgery

Palliative Care

Echocardiography

Home visits

Post Natal Depression

CCM COPD

PnuemoVax

Compliance packaging

Breast Screening



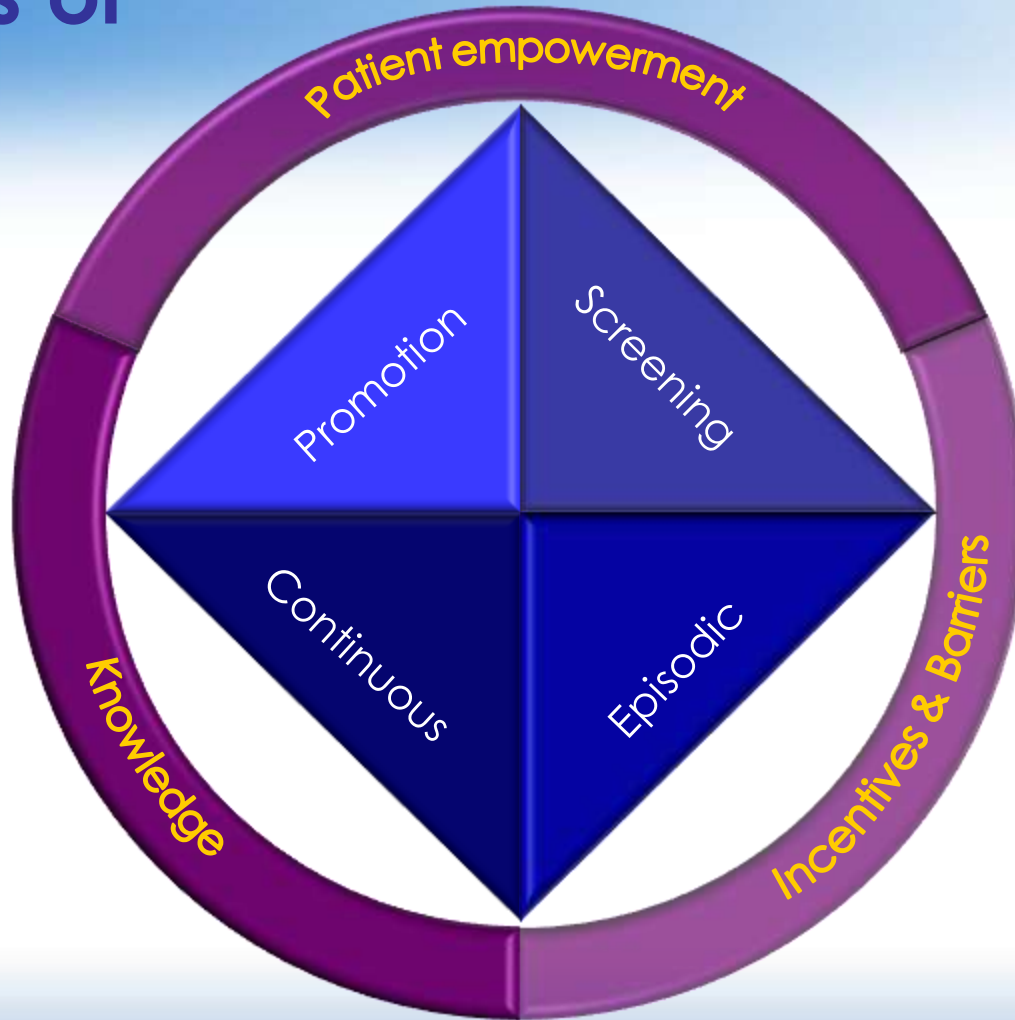
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“That’s our new mission statement.”



Systems of Care



Continuous Care





PNA Pallcare (130371.1)
 2e/27 Falcon Street, Parnell, 093757825

A 3 - R
 04 Nov 1943 66 yrs Male

ZZZ1250 E - Funded
 Cook Island Maori 0.00

JF
 RP

+ Patient Dashboard (ProCare)

PATIENT INFORMATION

- Ethnicity "Cook Island Maori" ■ Funded / Confirmed Enrolment
- **High Needs Patient**

PATIENT RISK FACTORS

■ Blood Pressure	Not recorded	Record
■ Height / Weight	Height or weight not recorded	Record
■ Waist Circum	Not recorded	Record
■ Alcohol	Not recorded	Record
■ Smoking	Cigarette smoker	26 Nov 2009 Screen Assessment
■ Diabetes Screen	No HBA1C recorded. Recommended (age over 50 or non European over 40)	Screen
■ CVD Screen	Not recorded	Screen
■ Cervical smear	Not relevant	
■ Mammography	Not relevant	
■ Vaccinations	Flu Vacc recommended	
■ Medications	On long-term medication	

LONG TERM CONDITIONS

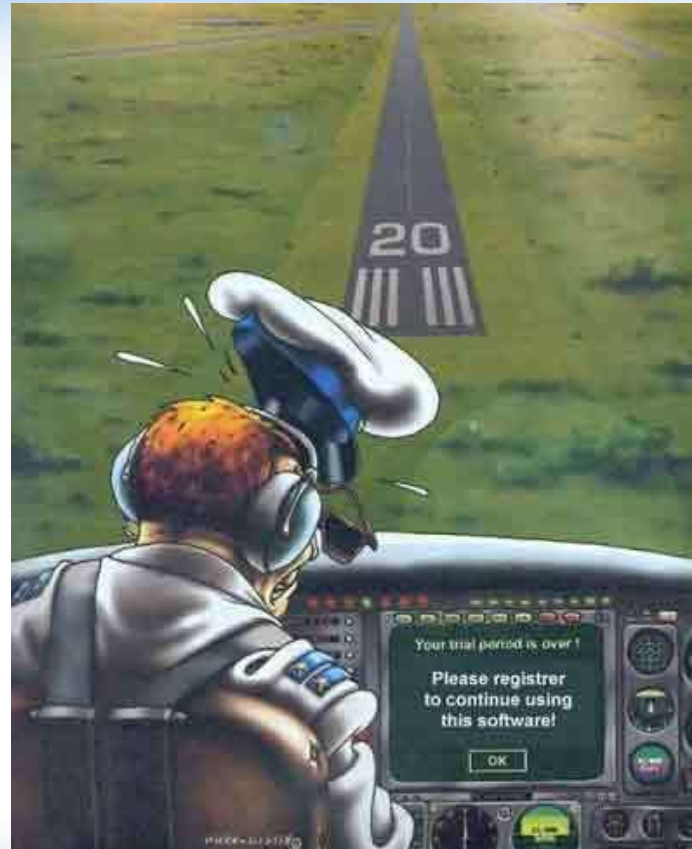
- IHD*
- Diabetic**
- Asthma*
- Heart Failure*
- Hypertension*
- COPD**

Read Code here

POTENTIAL PROGRAMMES AND SERVICES FOR THIS PATIENT

■ Child Oral Health	Eligibility	Detail	■ Engage	Eligibility	Detail	Consult
■ Integrated Heart Failure	Eligibility	Detail	■ ProExtra	Eligibility	Detail	Consult
■ Care Plus(CCO)	Eligibility	Detail	■ Diabetes Self Mgmt.	Eligibility		
■ OEP Falls Prevention	Eligibility	Detail	Enrol	■ CVD Screen/Mgmt(CCO)	Eligibility	Detail
■ Sexual Health	Eligibility	Detail	■ ProGRESS+(CCO)	Eligibility	Detail	Consult
			■ Diabetes Mgmt(CCO)	Eligibility	Detail	

CC Online Demonstration



Cardiovascular Risk using Electronic Clinical Decision Support (Predict®)

Before & After Audit of GP EMR for Evidence of CVD Risk Assessment

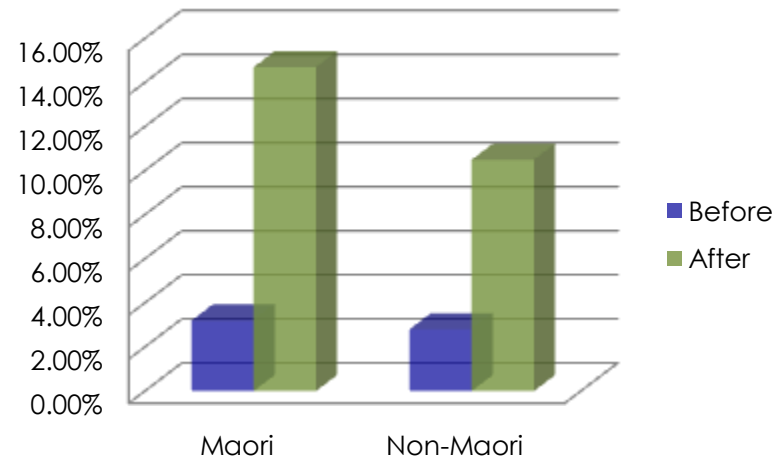
Results:

- 4 to 5 fold increase in CVD Risk Assessment in first year after Predict® installed
- Similar or greater increases for 'High Needs' patients

Predict® Version 2 :

- Released Jan 2007
- Higher screening rates
- Population reporting tools incorporated

CVD Risk Documented in EMR



Will a web-based cardiovascular disease (CVD) risk assessment programme increase the assessment of CVD risk factors for Maori? Whittaker R, Bramley D, Wells S, Stewart A, Selak V, Furness S, Rafter N, Roseman P, Jackson R. NZMJ 2006; 119



Consciousness test

► What does SIA mean?

- a) 'Services to Improve Access'?
- b) 'Senile Irate Australians'?

Under the capitation model do General Practices retain the right to charge co-payments?

- a) Yes
- b) no



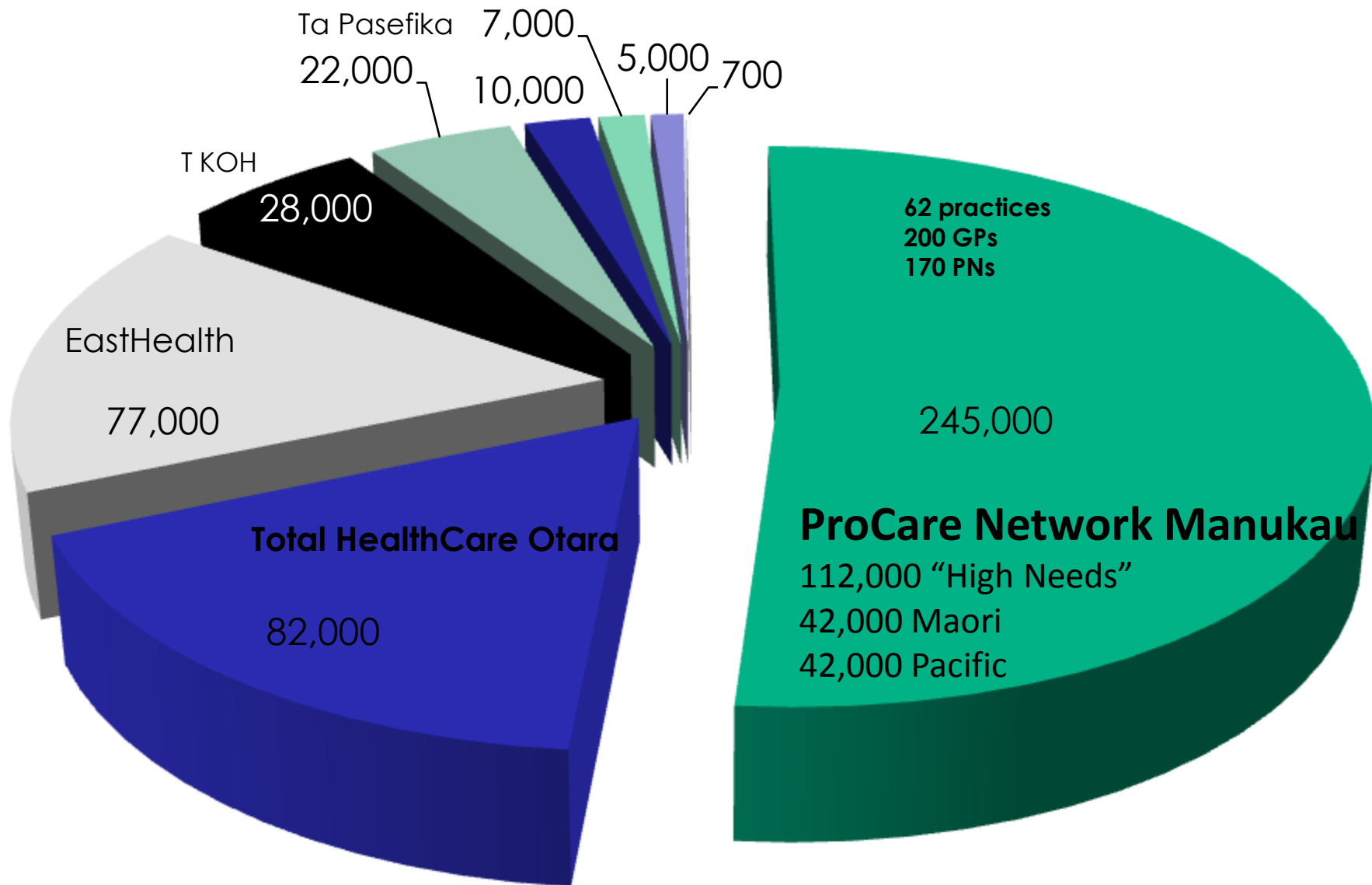
- ▶ **Which tool would you use to find out what services/programmes the patient in front of you may need:**
 - ▶ A) Continuous Care On-Line?
 - ▶ B) Patient Dashboard?
-
- ▶ **Who owns the IP for pavlova?**
 - ▶ A) Australia
 - ▶ B) NZ



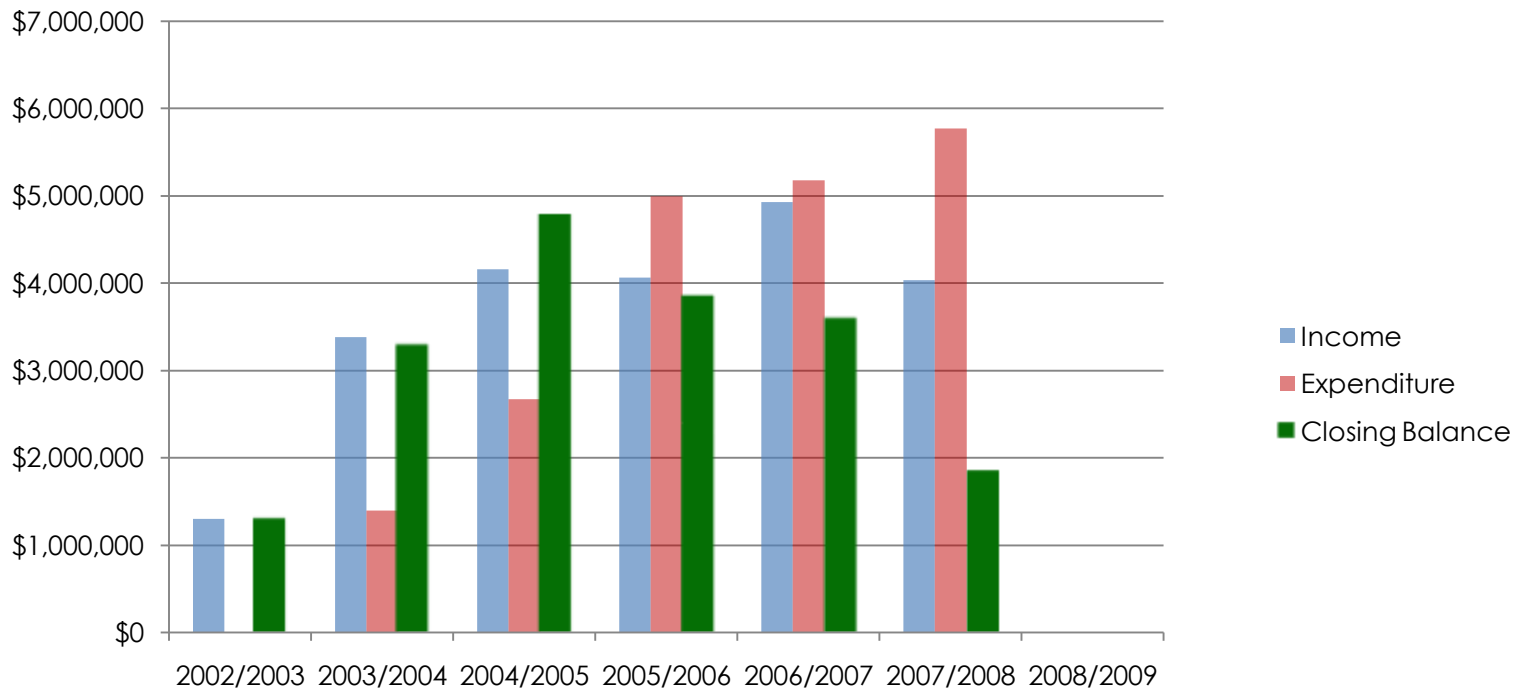
Episodic Care



South Auckland PHO Enrolled Populations



History of “SIA” Funding in ProCare Network Manukau (the South Auckland PHO)



What did we need to achieve ?

- ▶ Live within our needs
- ▶ Allow practices to decide which services/programmes were most important to them
- ▶ Incorporate better decision support – eligibility based on:
 - ▶ Demographics
 - ▶ Clinical need
 - ▶ Previous service utilisation or
 - ▶ Resource availability
- ▶ **Make resource allocation decisions nearer to the patient**



PROEXTRA 2.0 SOLUTION - LAUNCHPAD

Real-time business rule validation
Real-time clinical eligibility criteria

ProExtra Launchpad

ProExtra Services, *		
Beta-Blocker Initiation	(\$45.00)	■
ECG	(\$45.00)	■
Echo-Cardiogram	(\$292.50)	■
Engage Mental Health Consult	(\$50.00)	■
Home Visit	(\$45.00)	■
IUCD insertion	(\$150.00)	■
Insulin Initiation	(\$150.00)	■
Medication Packaging	(\$60.00)	■
Medication Reviews	(\$438.75)	■
Pneumococcal Vaccination	(\$60.00)	■
Sexual Health (U22)	(\$35.00)	■
Spirometry	(\$60.00)	■
Vasectomy	(\$325.00)	■

Service Key	
Exception: patient is ineligible for this service.	■
Patient may be eligible, but practice funds are too low.	■
Patient may be eligible and practice has required funds.	■

* All amounts include GST

ProCARE ProEXTRA Services **ProEXTRA**

NZMC / NZNC number:

NHI:

PMS Patient ID:

Date of birth: dd/mm/yyyy

Age: Years

Gender:

Funding Available
ProCare Test Practice #1
September, 2008

Current Balance	Days Left
\$1,843 61%	15 days 50%


Total Monthly: \$3,000


Real-time budget monitoring


Virtual budget allocation


PROEXTRA 2.0 SOLUTION – SERVICE PAGE


ProExtra Launchpad **Medication Packaging**

Patient Consent : Yes - No 

Date of Service : dd/mm/yyyy 

Reason for Request : 

Period of Supply : 

Patients Preferred Pharmacy Location : 

Provider's contract for this service is current.
[View Terms & Conditions](#) (Last Update on 26/03/2008)

I Accept Terms and Conditions Yes - No

REQUEST VOUCHER

Online service provision contract

Preapproved voucher request



PROEXTRA 2.0 SOLUTION – VOUCHER

Important Information for the Pharmacist

This voucher entitles you to invoice ProCare Network Manukau for the cost of providing medication packaging to the bearer of this voucher. You must have signed a 'ProExtra' contract with ProCare Network Manukau before we will reimburse you.



MEDICATION PACKAGING

PLEASE COMPLETE AND ATTACH TO YOUR INVOICE

NHI: ABC1235
Purchase Order Number: **99495869**

Medication packaging provided for (please tick):
 <1mth 1mth 2mths 3mths

Was packaging in addition to the above provided? (please tick):
 yes no

Additional packaging provided for (please tick):
 <1mth 1mth 2mths 3mths
 Please specify reason for additional packaging:

Mail or fax voucher and invoice to:

The ProExtra Administrator
ProCare Health Limited
PO Box 105 346
Auckland
Tel: 09 375 7815
Fax: 09 377 7826



Preapproved voucher

List of service providers via external data source

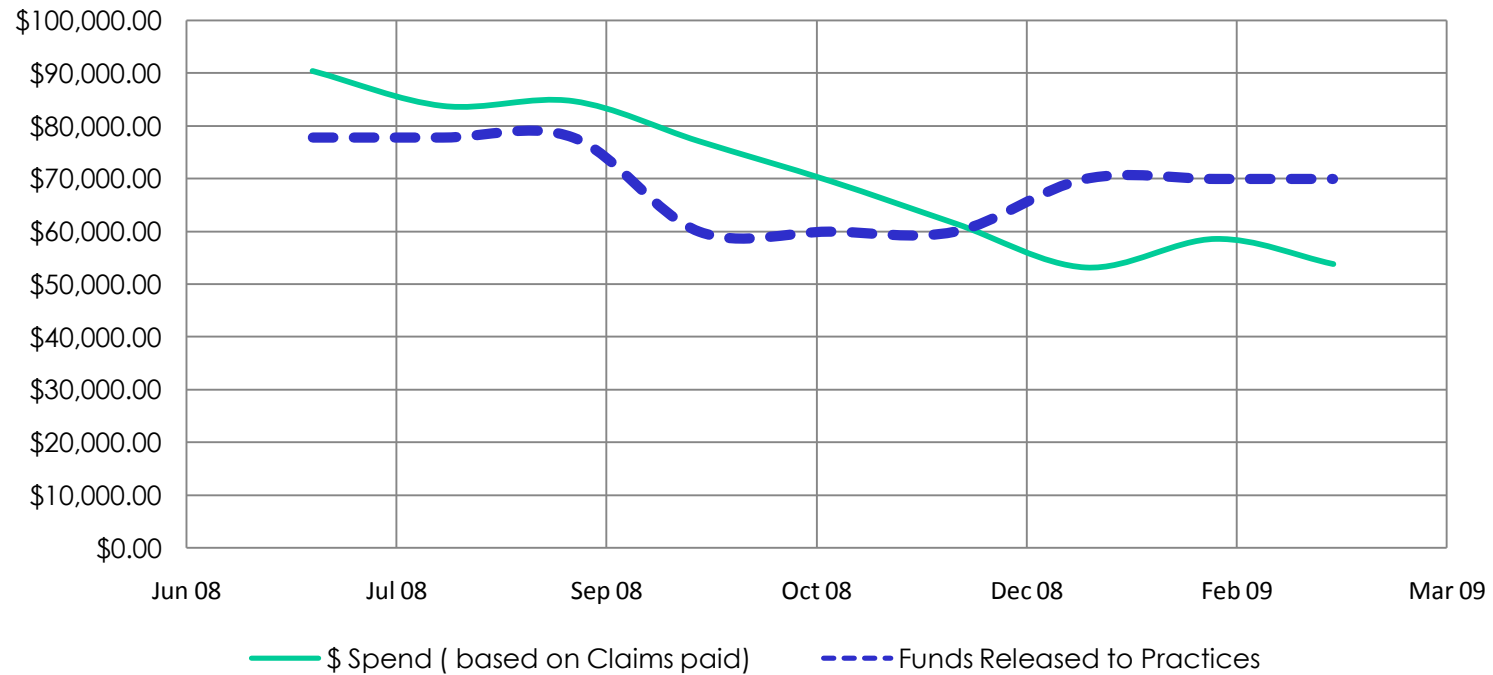
Please go to one of the following pharmacies:

Name	Address	Telephone & FAX
Clendon Pharmacy Ltd	Clendon Town Centre Clendon Manurewa Auckland	Phone: 09 267 0143 Fax: 09 267 3368
HealthCare Pharmacy, Clendon	9-11 Robert Ross Place Clendon Manurewa Auckland	Phone: 09 269 3646 Fax: 09 269 3647
Hillpark Pharmacy Ltd	77 Grande Vue Rd Manurewa Auckland	Phone: 09 267 2590 Fax: 09 267 2590



Did it work?

Total ProExtra \$ Spend vs Total Funds Released



Future Developments for ProExtra Demand Management

- ▶ Manage resources beyond SIA funding e.g.
 - ▶ Care Plus places
 - ▶ Elective Services Capacity
 - ▶ After Hours Eligibility
- ▶ Integrate with Continuous Care Online and Patient Dashboard



Innovations Currently in Development

- ▶ Population Health Database
- ▶ Revised (Online) Patient Dashboard
- ▶ Telehealth Home and Surgery solutions
- ▶ Consumer Health Portal
- ▶ Primary Care Referral Management System



- ▶ **Who said the following quote:**
- ▶ *'NZ is a country of inveterate, backwoods, thickheaded egotistic philistines':*
- ▶ A) John Lennon
- ▶ B) Vladimir Lenin



- ▶ Which of the following is regarded as appropriate etiquette when dining out in New Zealand?
- ▶ A) When decanting wine from the box, tilt the paper cup and pour slowly so as not to bruise the wine
- ▶ B) If drinking from the bottle, hold it with only one hand



Community and Patient Empowerment



Patient Self Management

- ▶ Flinders – Practice Based
- ▶ Stanford Group Model
- ▶ Patient Held Wellness Plans
- ▶ Patient Support Groups
- ▶ Lifestyle Coordinators
- ▶ Community Development
- ▶ Community Health Coordinators



Lifestyle Coordinators

- To improve community health & wellbeing by building 'grass roots' capacity and capability.
- Community people contracted out with Trusts.
- Increase levels of physical activity & improve nutrition of members of the setting/community.
- Strengthen skills & knowledge and facilitate action.



Marae whanau participate in needs Assessments with Kaiwhakahaere

- ▶ 420 needs assessments completed
- ▶ Needs Assessments Outcomes ensures programs are targeted to marae needs
- ▶ Not just a circular but a living breathing document
- ▶ 5 target areas, GP Services, Levels of Physical Activity, Knowledge of Nutritious Foods, The Marae Environment and Barriers to being active and eating healthy kai

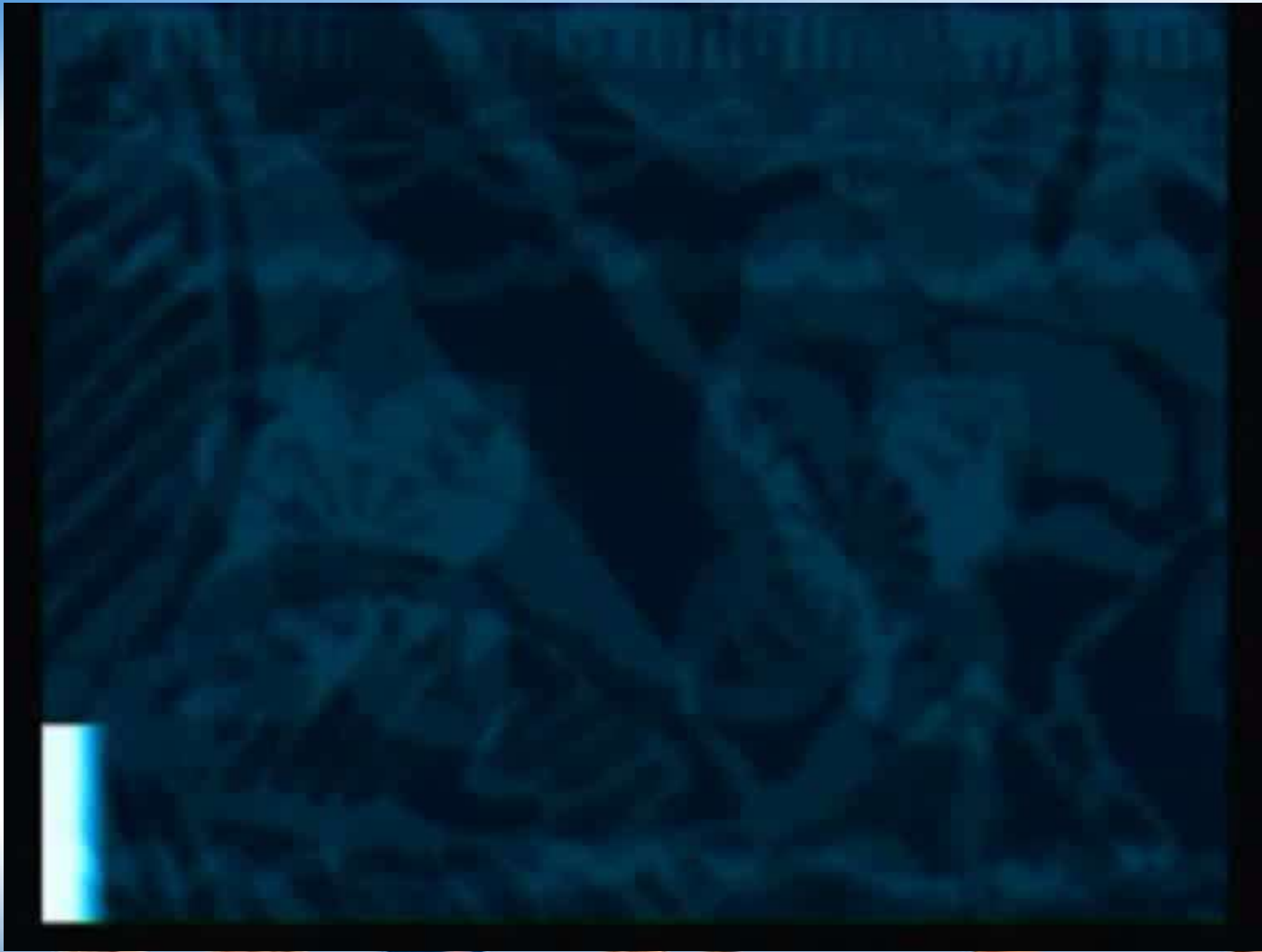
Huakina Development Trust







Community Health Coordinators



A Patient's Journey





Tania Rerekura

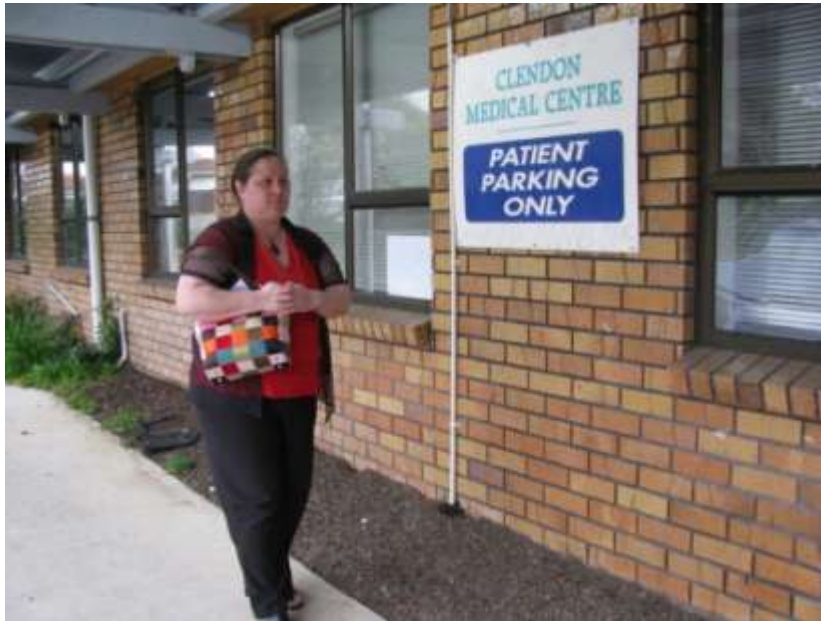
- ▶ Female
- ▶ 48yrs old
- ▶ Māori
- ▶ No Contact with practice for 15 months
- ▶ Did not respond to three letters for recall re cervical smear screening.



Referred to Community Health Worker



Assisted to Attend Practice



Tania Sees The General Practice Team



Patient Dashboard : A Population Health Tool

Web Patient Dashboard (ProCare)

PATIENT INFORMATION

- Ethnicity "Cook Island Maori" ■ Funded / Confirmed Enrolment
- High Needs Patient

PATIENT RISK FACTORS

Factor	Value	Date	Action
Blood Pressure	120/80	13 Apr 2005	Record
Weight / Height	65kg, 157cm, BMI 26	10 Nov 2005	Record
Alcohol	1-2 units / day	20 Feb 2006	Record
Smoking	30	6 Oct 2005	Record
Diabetes Screen	Recommended (age)		Screen
CVD Screen	Not relevant		
Cervical smear	First Normal	19 Aug 2005	Read Code here
Mammography	Not relevant		
Depression	Not recorded		Screen
Vaccinations	Not relevant		
Medications	No long-term medication		

CLASSIFICATIONS

- IND
- Diabetic
- Asthma**
- History of CHF
- Hypertension
- CVD

POTENTIAL PROGRAMMES AND EPISODIC CARE CONSULTS FOR THIS PATIENT

Programme	Eligibility	Detail	Enroll	Engage	Eligibility	Detail	Consult
■ Care Plus	Eligibility	Detail	Enroll	■ Engage	Eligibility	Detail	Consult
■ Care Plus / CVD	Eligibility	Detail		■ Palliative Care	Eligibility	Detail	Consult
■ CVD Case Management	Eligibility	Detail		■ Post Natal Depression	Eligibility	Detail	Consult
■ Heart Care	Eligibility	Detail		■ ProExtra	Eligibility	Detail	Consult
■ Smoking Cessation	Eligibility	Detail	Enroll	■ U22 Sexual Health	Eligibility	Detail	
				■ U25 Sexual Health	Eligibility	Detail	

[Help](#) [Text Log](#) [Set PHO ID](#) Version 2.4

- ▶ Dashboard flags that a CVD screen is indicated (Māori female older than 45)
- ▶ Tania has a blood test and is found to have Type 2 Diabetes Mellitus
- ▶ She is recalled for further assessment and care



File Edit Patient Module Report Tools Utilities Setup Window Help

REREKURA Tania (130350.1) A 3 - R ABC1235 E - Funded SFE
 18 Aug 1960 48 yrs Female Maori - NZ 0.00 RP

New CVD Diabetes Predict Procure (Predict)

Web More Audit

NZ CVD / DIABETES PROGRAMME

DEMOGRAPHICS **CVD RISK ASSESSMENT** CVD RISK MANAGEMENT DIABETES MANAGEMENT

This page should be completed for all patients. All underlined items are required.

After submitting this form, additional follow up management forms become available to you. The secondary Diabetes management form will become available dependant upon the status of the Diabetes field on this form.

NOTE: It is inappropriate to do CVD risk assessment in pregnancy.

ASSUME NEGATIVE DEFAULTS

Clinical History

Family History of Premature CVD Yes - No

Angina Yes - No

MI Yes - No

PCI/CABG Yes - No

Ischaemic Stroke Yes - No

Transient Ischaemic Attack (TIA) Yes - No

PVD Yes - No

Diabetes Type 2 (incl Type 2 on insulin)

ECG confirmed Atrial Fibrillation Yes - No

Diagnosed Genetic Lipid Disorder None

Diagnosed metabolic syndrome Yes - No

Smoking History Yes - up to 10 / day

Pregnant? Yes - No

Examination

Most recent BP (Sitting) 145 / 100 mmHg

Previous BP (Sitting) 145 / 98 mmHg

TC/HDL ratio 7 - Date: 18/09/2008 dd/mm/yyyy

Total Cholesterol 4 mmol/L - Date: 18/09/2008 dd/mm/yyyy

For diabetic patient

Diabetes: year of diagnosis 2008

Print Save Cancel Help

Assessment and management recommendations are assisted by Predict



Tania has a very high CVD risk

New CVD Diabetes Predict Procure (Predict)

Web More Audit

RISK ASSESSMENT INFO

"WHAT IF" / "DEMO" - Risk Assessment: Send | Print | Export to PDF
 This page was made specifically for **TANIA REREKURA (ABC1235)**: 18-Sep-2008 17:14 hrs

Estimated risk of having a CVD event in the next 5 years: 26%

Estimated risk level: 5-year CV risk (fatal and non-fatal)	Estimated Benefits: NNT for 5 years to prevent one event (CVD events prevented per 100 people treated for 5 years)		
	1 intervention (25% risk reduction)	2 interventions (45% risk reduction)	3 interventions (55% risk reduction)
26%	15 (6.5 per 100)	9 (11.7 per 100)	7 (14.3 per 100)

Based on the conservative estimate that each intervention: aspirin, blood pressure treatment (lowering systolic blood pressure by 10 mm Hg) or lipid modification (lowering LDL-C by 20%) reduces CV risk by about 25% over 5 years.

CVD risk has been moved up one risk category (5%), as cardiovascular risk may be underestimated in the Framingham risk equation; based on:

- Maori or Pacific ethnicity or people from the Indian subcontinent
- type 2 diabetes with an HbA1c consistently greater than 8%

Cardiovascular Disease: Baseline Risk and Treatment Benefit

DIABETES
 (With a 5% upward risk adjustment applied)

Nonsmoker Smoker

Ratio of Total Cholesterol:HDL

	4	5	6	7	8
180/105	Yellow	Yellow	Yellow	Yellow	Yellow
160/95	Yellow	Yellow	Yellow	Yellow	Yellow
140/85	Green	Green	Green	Green	Green
120/75	Dark Green	Dark Green	Dark Green	Dark Green	Dark Green

	4	5	6	7	8
180/105	Orange	Orange	Orange	Orange	Orange
160/95	Orange	Orange	Orange	Orange	Orange
140/85	Yellow	Yellow	Yellow	Yellow	Yellow
120/75	Green	Green	Green	Green	Green

The colour chart and calculated risks vary. Likely cause: patient age or BP fall between two colour chart groups.
 Calculated risk value: 26% - Indicated risk range: (30-100%)

Risk Level 5 year CVD risk (non-fatal and fatal)		
Very High	High	Mild
>30%	15-20%	5-10%
25-30%	10-15%	2.5-5%
20-25%	<2.5%	

Print Save Cancel Help



MedTech-32 Procure Test

File Edit Patient Module Report Tools Utilities Setup Window Help

REREKURA Tania (130350.1) A 3 - R ABC1235 E - Funded SFE
18 Aug 1960 48 yrs Female Maori - NZ 0.00 RP

New CVD Diabetes Predict Procure (Predict)

Web More Audit

DEMOGRAPHICS CVD RISK ASSESSMENT CVD RISK MANAGEMENT DIABETES MANAGEMENT

ACTIONS RECOMMENDATIONS PATIENT INFORMATION RISK ASSESSMENT INFO

"WHAT IF" / "DEMO" - Patient Information: Send | Print | Export to PDF
This page was made specifically for **TANIA REREKURA (ABC1235)**: 18-Sep-2008 17:17 hrs

CVD Risk

- You have diabetes and your risk of developing heart disease or blood vessel disease or having a stroke in the next 5 years is classified as very high (20-30%). This means that for every 100 people like you, 20-30 will develop a problem in the next 5 years. The **good news** is there are lots of ways you can reduce this risk.
[\[NHF booklet- reducing the risk of heart attack and stroke \(www.nhf.org.nz\)\]](#)
- Sometimes making changes can seem quite overwhelming - talk to your doctor or nurse about how you can get started. The benefits of tackling your risk factors start immediately and continue for as long as you maintain the change. Beneficial changes include lifestyle, diet, drug therapy and quitting smoking (if you are a smoker). The changes that will reduce **YOUR** risk are described on this page.

Lifestyle

- Regular physical activity and a diet that protects your heart will improve your general health, control your diabetes, help lower your blood pressure, and improve your cholesterol and triglycerides (blood fats) and other factors. Your doctor may refer you for special dietary advice so that you can get advice tailored just for you.
[\[Diabetes NZ- Fit for life \(www.diabetes.org.nz\)\]](#)
[\[Diabetes NZ- Basic guide to food \(www.diabetes.org.nz\)\]](#)
[\[Tackling your risk factors-Eating and Nutrition \(www.nhf.org.nz\)\]](#)
- Get more active. The long term aim is 30 minutes of physical activity on most days of the week (or 3 lots of 10 minutes a day). Set a goal and go for it!
[\[Diabetes NZ- Fit for life \(www.diabetes.org.nz\)\]](#)
[\[Walking / Stretching / Physical activity for people with medical conditions \(www.PushPlay.org.nz\)\]](#)
[\[Tackling your risk factors-physical activity \(www.nhf.org.nz\)\]](#)
- Your weight is above the recommended healthy weight. If you are not already involved in a healthy lifestyle programme, ask your doctor or practice nurse about your options. The target is to lose 10% of your initial weight. This may take some time but once you have achieved this weight loss, aim to maintain your weight at this new level.
[\[Tackling your risk factors- Weight management \(www.nhf.org.nz\)\]](#)
- No matter how long you have smoked or what age you are, if you quit smoking you will benefit straight away. For example, within one day of quitting smoking the risk of having a heart attack starts to drop. In 2 days your ability to smell and taste gets better. Between 2 weeks and 3 months your circulation and lung function will have improved. (Quitline phone number is 0800 778 778)
[\[Nicotine gum \(www.quit.org.nz\)\]](#)
[\[Nicotine patches \(www.quit.org.nz\)\]](#)
[\[Smoking \(www.quit.org.nz\)\]](#)
[\[Tackling your risk factors- smoking \(www.nhf.org.nz\)\]](#)
[\[Tips for quitting smoking \(www.quit.org.nz\)\]](#)

Print Save Cancel Help

Predict generates Patient specific Advice



Consults Nurse For Self-Management Education



- ▶ Condition explained – Tania sees how she can modify her risk using “Heart Forecast” tool
- ▶ Self management programme initiated
- ▶ Enrolled on Care Plus
- ▶ Referred to Modified Green Prescription



Modified Green Prescription



MedTech-32 Procure Test

File Edit Patient Module Report Tools Utilities Setup Window Help

REREKURA Tania (130350.1) A 3 - R ABC1235 E - Funded SFE
18 Aug 1960 48 yrs Female Maori - NZ 0.00 RP

New CVD Diabetes Predict Procure (Predict)

Web More Audit

DEMOGRAPHICS CVD RISK ASSESSMENT CVD RISK MANAGEMENT DIABETES MANAGEMENT

ACTIONS RECOMMENDATIONS PATIENT INFORMATION RISK ASSESSMENT INFO

"WHAT IF" / "DEMO" - Actions: Send | Print | Export to PDF
This page was made specifically for **TANIA REREKURA (ABC1235)**: 18-Sep-2008 17:17 hrs

Lifestyle

- Reassess dietary pattern and physical activity today
- Refer to dietitian
- Give Green Prescription
- Assess willingness to quit smoking
- Discuss weight management

Renal

- Lab results indicative of renal impairment. If confirmed, rerun risk assessment and diabetes management selecting renal disease present

Glycaemic Control

- Undertake 3- to 6-month trial of intensive lifestyle interventions
- Start metformin (if HbA1c not improving with trial of lifestyle interventions)
- Refer for diabetes self-management education
- Check HbA1c in 3 months

Blood Pressure

- BP therapy - check compliance, optimise dosage or add another agent
- Add or change to an ACE inhibitor

Aspirin

- Start aspirin (or alternative) if no history of haemorrhagic stroke or other contra-indications

Lipids

- Repeat lipid test (fasting) if required to establish accurate baseline
- Start statin after baseline transaminase level (ALT) taken
- Check fasting lipids and LFTs in 3 months

Feet

- Assess 3-6 monthly (if have 'high risk' foot), otherwise annually

Eyes

Print Save Cancel Help

Predict Recommends Polypharmacy



Pharmacotherapy

Clendon Medical Centre

- Rx Aspirin 100mg
Sig: 1 od
- Rx Metformin 500
Sig: 2 bd
- Rx Simvastatin 40mg
Sig: 1 nocte
- Rx Cilazapril 2.5mg
Sig: 1 Mane
- Rx Compliance
Packaging 3 months

P B Didsbury

“Adherence to long term therapy for chronic illness in developed countries averages 50%”

Adherence to Long-Term Therapies: Evidence for Action: World Health Organisation 2003



ProExtra Launchpad

ProExtra Services, *

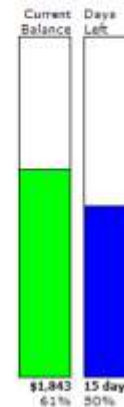
Beta-Blocker Initiation	(\$45.00)	■
ECG	(\$45.00)	■
Echo-Cardiogram	(\$292.50)	■
Engage Mental Health Consult	(\$50.00)	■
Home Visit	(\$45.00)	■
IUCD insertion	(\$150.00)	■
Insulin Initiation	(\$150.00)	■
Medication Packaging	(\$60.00)	■
Medication Review	(\$438.75)	■
Pneumococcal Vaccination	(\$60.00)	■
Sexual Health (U22)	(\$35.00)	■
Spirometry	(\$60.00)	■
Vasectomy	(\$325.00)	■

Service Key

Exception: patient is ineligible for this service.	■
Patient may be eligible, but practice funds are too low.	■
Patient may be eligible and practice has required funds.	■

Funding Available

* ProCare Test Practice #1 -
September, 2008



Total Monthly: \$3,000

* All amounts include GST



ProEXTRA Services



NZMC / NZNC number:

NHI:

PMS Patient ID:

Date of birth: dd/mm/yyyy

Age: Years

Gender:

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[Logout](#)



ProExtra Launchpad

Medication Packaging

Patient Consent : Yes - No



Date of Service : dd/mm/yyyy

Reason for Request :

Period of Supply :



Patients Preferred Pharmacy Location :

Provider's contract for this service is current.
[View Terms & Conditions](#) (Last Update on 26/03/2008)

I Accept Terms and Conditions Yes - No

REQUEST VOUCHER

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Important Information for the Pharmacist

This voucher entitles you to invoice ProCare Network Manukau for the cost of providing medication packaging to the bearer of this voucher. You must have signed a 'ProExtra' contract with ProCare Network Manukau before we will reimburse you.



MEDICATION PACKAGING

PLEASE COMPLETE AND ATTACH TO YOUR INVOICE

NHI: ABC1235
Purchase Order Number: **99495869**

Medication packaging provided for (please tick):
 <1mth 1mth 2mths 3mths

Was packaging in addition to the above provided? (please tick):
 yes no

Additional packaging provided for (please tick):
 <1mth 1mth 2mths 3mths
 Please specify reason for additional packaging:

Mail or fax voucher and invoice to:

The ProExtra Administrator
 ProCare Health Limited
 PO Box 105 346
 Auckland
 Tel: 09 375 7815
 Fax: 09 377 7826



Please go to one of the following pharmacies:

Name	Address	Telephone & FAX
Clendon Pharmacy Ltd	Clendon Town Centre Clendon Manurewa Auckland	Phone: 09 267 0143 Fax: 09 267 3368
HealthCare Pharmacy, Clendon	9-11 Robert Ross Place Clendon Manurewa Auckland	Phone: 09 269 3646 Fax: 09 269 3647
Hillpark Pharmacy Ltd	77 Grande Vue Rd Manurewa Auckland	Phone: 09 267 2590 Fax: 09 267 2590



At The Pharmacy



- ▶ Pharmacist dispenses Rx in blister packs
- ▶ Educates regarding medicines
- ▶ Notifies General practice if patient is late in picking up repeats




2 months later -problems at large:

- ▶ Tania's step daughter resents her relationship with her partner
- ▶ Tania's job at the carpet mill is under threat
- ▶ Tania scores 25 on Kessler score, she is referred to ProCare Psychological Services




Service will only be provided to patients who score a Kessler score of 16 or more. This is a prerequisite in order to request a voucher.

Assessments and Actions

Patient Consent : Yes - No 

Consult Type

Date of Service : dd/mm/yyyy 

Enter Kessler 10 manually Yes - No

Kessler 10 Score

Interpretation

Assessment

Personal history Yes - No

Family History Yes - No

Severity of condition

Safety issues

Psychosocial issues

Medicines prescribed today

Has follow-up been scheduled Yes - No

Follow up within 2 weeks doubles the rate of compliance with medication.

Services

Psychologist

Psychiatrist

Secondary mental health services

CHC

None

Other

Provisional Diagnosis

Schizophrenia

Addictive disorder

Adjustment disorder

Post natal depression

Bipolar disorder



New Patient Document

Main Services More Audit

Document Details

Document: Psyc Referral (PPSTXT) To: Park Document

PMHO Services Referral Form

To:

Date: 16 Sep 2008

From: **Dr Sam Entwistle** Millstone Family Practice
 Phone: 09 358 0116
 Fax:

Patient Name: Jayne Gattes
 Address: 3090 Epsom Road
 Epsom Auckland

Date of Birth: 08 Oct 2006 Age: 23m Gender: Female NHI: ABC1235 Ethnicity: Cook Island Maori

Contact Numbers

Day Phone: 654 6655
 After Hours Ph:
 Mobile Phone:
 Other Phone: _____

APPOINTMENT INFORMATION

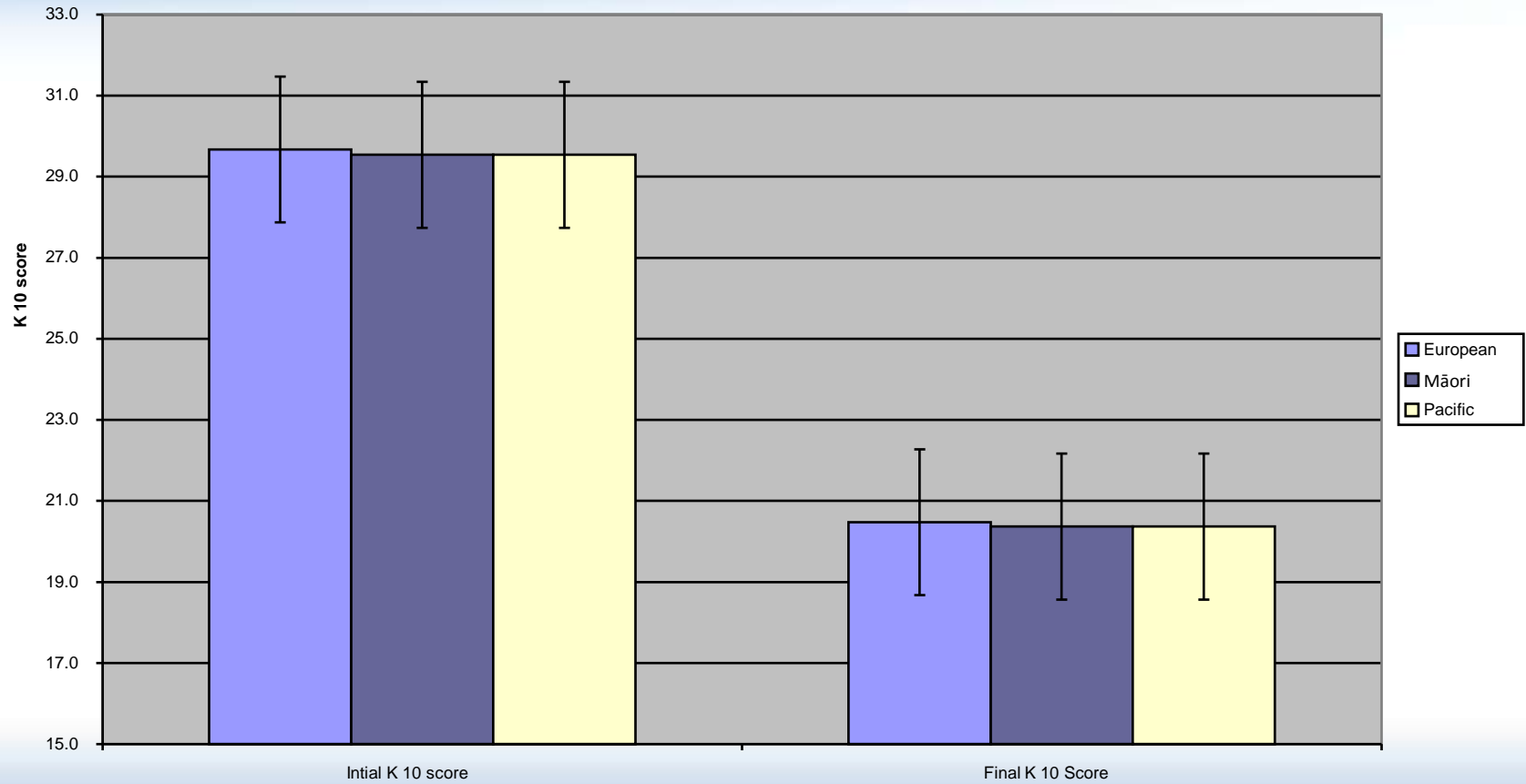
Brief information regarding the need for psychologist (Please include any co existing medical conditions), Community Health worker or Whanau support input.

Document Options

Printer: WebEx Document Loader Provider: Sam Eaves (SFE) Copies: 1



Kessler 10 Outcomes



In Summary

Key Take-Outs

- ▶ Whole patient not the disease condition
- ▶ Central role of CHCs
- ▶ Multiple treatments co-ordinated by GP through range of community providers
- ▶ Snapshot of a small fraction of the programmes available to ProCare GPs to provide care

Programmes Used

- ▶ Community Health Workers
- ▶ Health Promotion commissioned exercise programme - GR_x
- ▶ Predict
- ▶ Care Plus
- ▶ Medicine compliance packaging
- ▶ ProCare Psychological Services



Critical Success Factors

- ▶ Understanding 'population health' i.e. what is your denominator?
- ▶ Engagement of primary care teams
- ▶ Aligning incentives
- ▶ Flexible use of workforce
- ▶ Extending the reach of primary care into the community

