

News release

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Page 1/2

### **CMDHB provides extra support to those with Chronic Conditions**

Counties Manukau District is expanding its innovative health programme to give more support and empowerment to people living with long term health conditions.

The District has developed Chronic Care Management (CCM) - a system for providing specialist levels of care to patients with long-term health conditions, in a community and family based setting.

Previously, patients with complex chronic conditions like diabetes, cardiovascular disease, some lung diseases or congestive heart failure, had to visit a hospital outpatient clinic to receive care. Hospital based specialists now give training and support to general practice teams so they are able to support the provision of services and advice. "The DHB is also providing extra funding to ensure patients are supported on an ongoing basis, with full reviews every three months and around six free hours of nursing support spread over a year" says John Wellingham, Medical Director of CCM.

CCM focuses on providing the best possible care, in the right place at the right price. Nurse Specialist Andy McLachlan says the patient is the expert on how they live, their environment and what is best for them so patient-centred approaches are vital. "Working with people with any chronic condition is about building a relationship where open and honest discussion can take place - where the emphasis is on learning what works best for the client to help them make the best health choices that they can".

Nurse specialist Megan Goodman says the CCM team aims to overcome some of the barriers that stop people seeking the care they need. "Community health workers are available through some PHOs to support people attending health appointments. We can subsidise some hospital parking costs, arrange access to hospital-based

investigations and provide ongoing education and social contact through community support groups”.

Another essential aspect of CCM is the sharing of health information between all providers involved in a patient’s treatment. Each patient is screened against best practice data to determine the most effective care. This information is then shared between the patient and their health professional, with selected parts being made available to secondary healthcare providers if needed.

A ‘Wellness Plan’ is a key document for patients in the CCM programme. It contains a general profile of the patient as well as current medications, goals, information about their disease and an important ‘action plan’ for if they become unwell. Patients are encouraged to take their plan to all health appointments to increase the sharing of appropriate information. “Sharing information reduces the number of times the patient has to repeat their story and ensures healthcare providers are informed to make important decisions about the management of the patient’s chronic condition. It gives patients a better chance of maintaining or regaining the level of health they would like” says CCM Liaison and IS manager Sarah Tibby.

Accurate reporting and sharing of information ensures patients who have missed appointments or aren’t up-to-date on their care do not fall through the gaps.

Early in November CCM formally acknowledged links to the Let’s Beat Diabetes programme, which aims to reduce the burden of diabetes in the people of Counties Manukau. The two programmes running as one provides an integrated community, primary care and hospital service for people with diabetes. “Our goal has always been to provide the best possible care, in the right setting, at the right price. We are now very close to achieving this” says John Wellingham.

**For media enquiries or more information please call Candice Bowen at Lauren Young and Associates on 09) 378 8433 or 027 276 1797.**