The concept of a Year of Care

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Why focus on chronic conditions

- They represent a significant proportion of clinical work in both acute and primary care
- The evidence suggests:
  - That one half of the top 40 HRGs (that explain about 50% of A&E generated bed days) reference chronic conditions with a high rate of re-admission
  - considerable variation in the way that these are managed in primary care to the detriment of:
    - clinical effectiveness and
    - efficient resource usage

High volume case types- DGH (4)

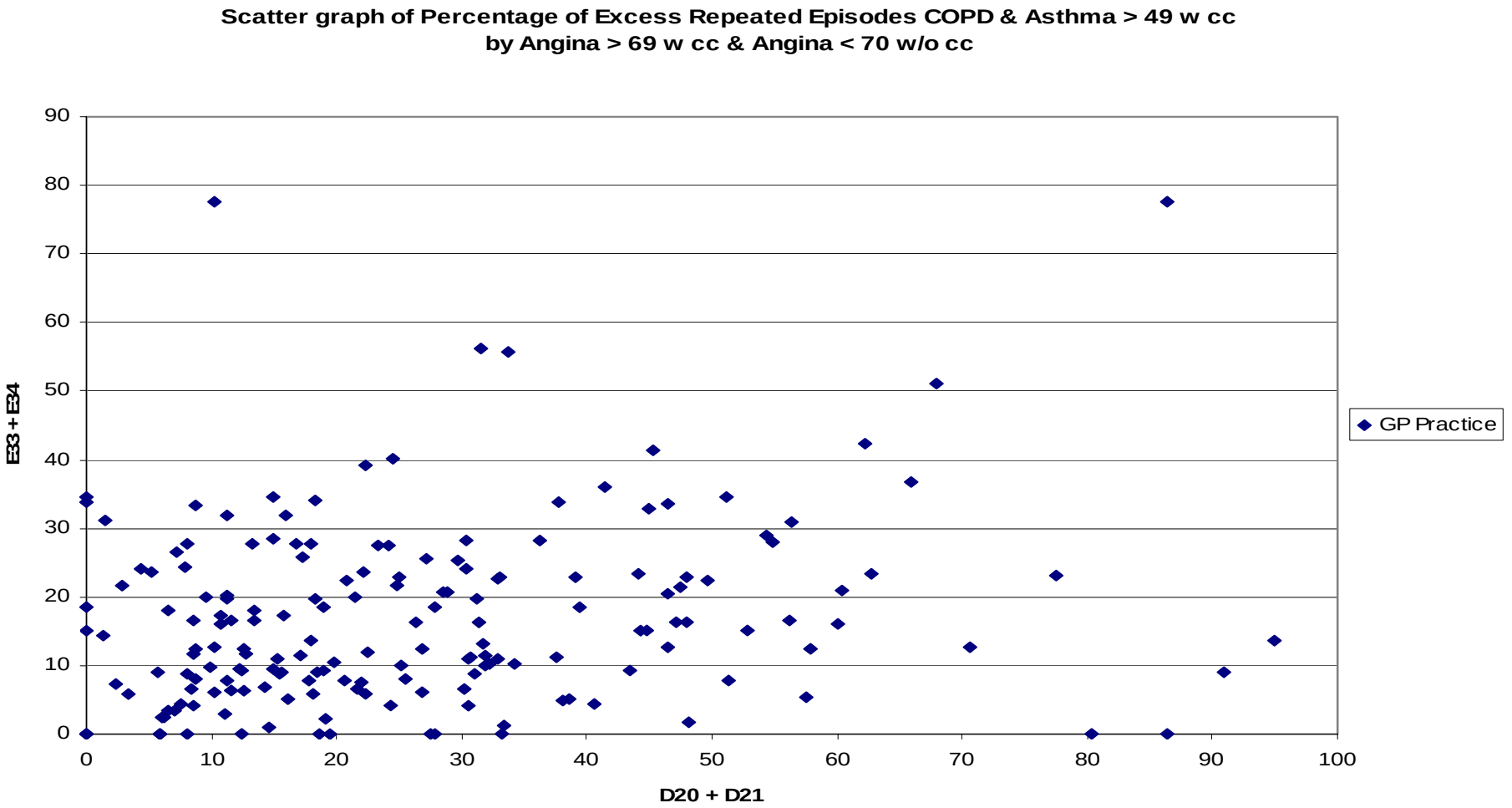
- Emergency admissions account for 53% of all care episodes and 82.9% of all bed days consumed within the Trusts
- 30 HRGs (out of 547) account for 46% of all emergency episodes and these HRGs account for 39% of all emergency generated bed days within the Trusts.
- 18 of these 30 HRGs reference conditions (usually chronic) with a high risk of repeated emergency admission. These patients tend to account for 32.8% of all emergency patient episodes and 17.6% of all bed days.

High Volume Emergency Admissions – Repeated Adm

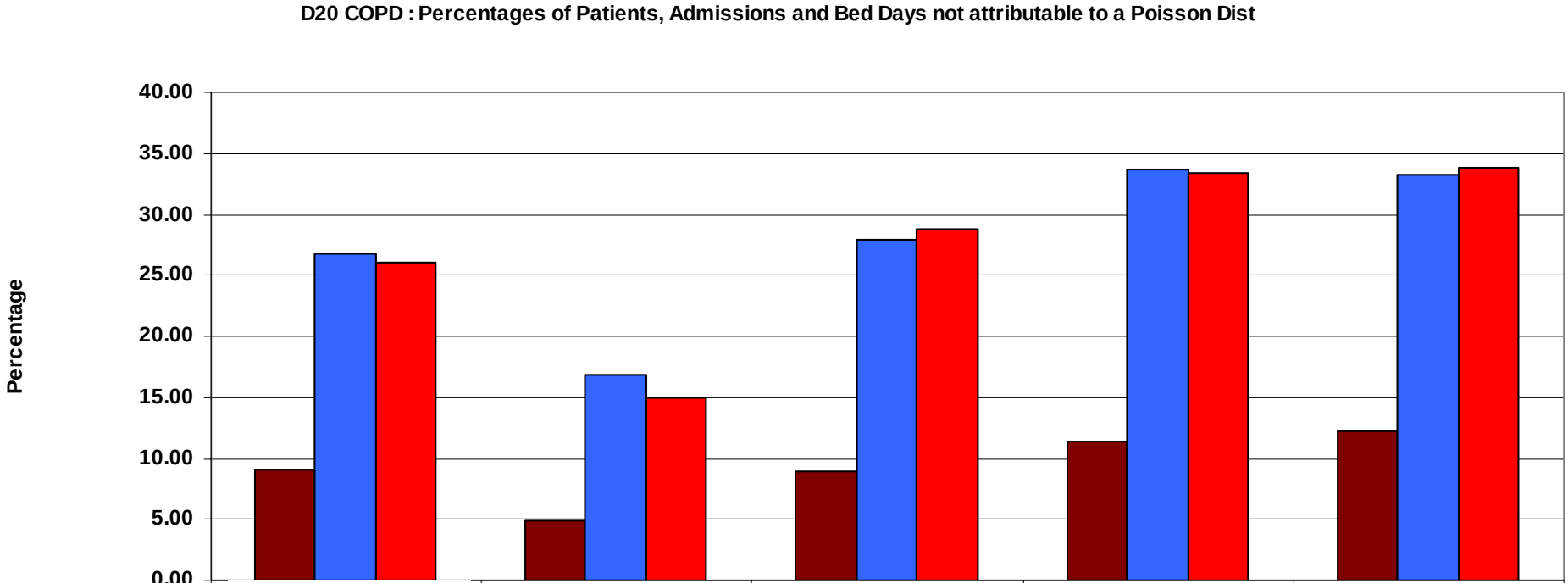
HRG	HRG label	% Adm	% B Days
D20	Chron Obstruct Pulmonary Dis/Bronch	37.22	39.16
S16	Poison Toxic Effects /Overdoses	18.25	17.62
P06	Minor Infections (incl Immune Disord)	5.41	7.73
E36	Chest Pain <70 w/o cc	7.47	7.81
D21	Asthma >49 or w cc	1.44	1.41
F47	Gen Abdom Disord <70 w/o cc	4.84	7.85
E33	Angina >69 or w cc	18.11	18.73
H42	Sprains Strains /Minr Open Wounds <70 w/o cc	1.43	1.11
L09	Kidney/Urin Tract Infections >69 or wcc	3.77	2.92
D99	Comp Eld w a Respiratory Sys PDx	6.54	5.81
E18	Heart Fail/Shock >69 or wcc	6.67	5.38
E29	Arrhythmia/Conduction Disord >69 or wcc	4.68	3.37
P13	Other Gastro/Metabol Disord	9.16	15.09
E31	Syncope/Collapse >69 or wcc	2.87	3.31
F46	Gen Abdom Disord >69 or wcc	5.78	4.44
E12	Acute Myocardial Infarction w/o cc	0.66	0.37
P03	Upper Respiratory Tract Disord	5.73	9.07
E35	Chest Pain >69 or w cc	7.26	6.99
P15	Accidental Injury	1.68	1.38
P04	Lower Respiratory Tract Disord	11.37	21.33
E34	Angina <70 w/o cc	13.65	17.11
F17	Stom/Duod Disord >69 or wcc	2.22	2.17
A22	Non-Transient Stroke/CVA >69 or wcc	0.10	0.12
D13	Lobar Atyp/Viral Pneumon >69 or wcc	2.13	2.33

Variation in Chronic Disease Management between GP Practices

Percentages of hospital patient admissions for COPD & Angina by GP practice



COPD
Percentage of potential reductions in patients, admissions and bed days by Trust



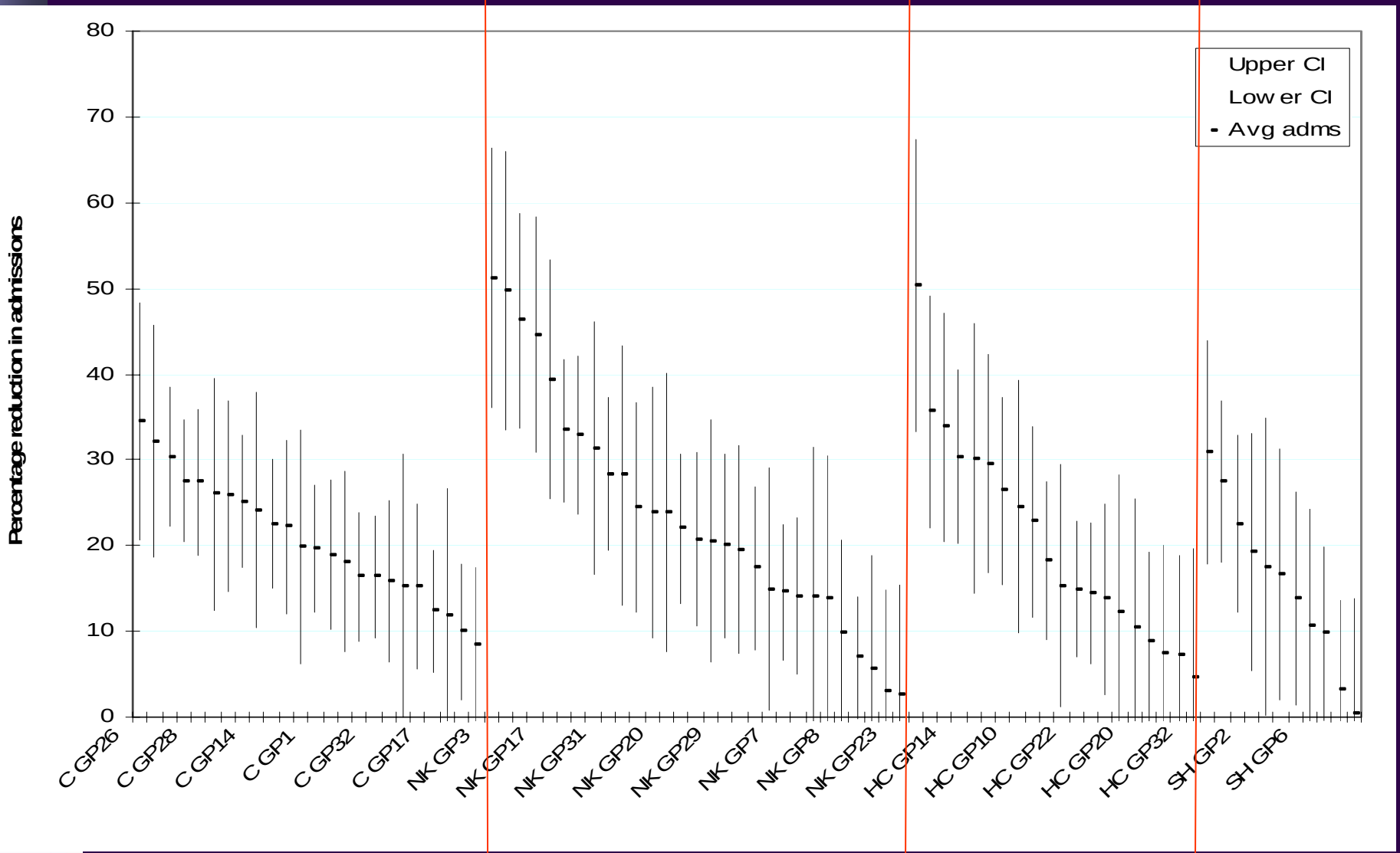
	Trust E	Trust A	Trust B	Trust C	Trust D
%Patients	9.00	4.83	8.98	11.36	12.18
%Admissions	26.73	16.86	27.92	33.71	33.26
%Bed Days	26.01	14.98	28.74	33.39	33.75

Readmissions to any HRG

		% of emergency admissions that have higher than expected readmission rate	Potential bed day savings for all emergency admissions	Bed-day savings per day	Savings as a percentage of total trusts' beds per day
SHA 1	**Trust A - C&H**	20%	49,956	137	12%*
	Trust B	25%	134,789	369	12%
SHA 2	**Trust1**	17%	34,957	95	11%
	Trust2	19%	27,560	75	10%
	Trust3	20%	18,787	51	11%
	Trust4	21%	45,972	125	10%
	Trust5	23%	67,807	185	14%

*based on C&H having 1,127 beds

Potential percentage reduction in respiratory admissions by GP practice (2003-2004)



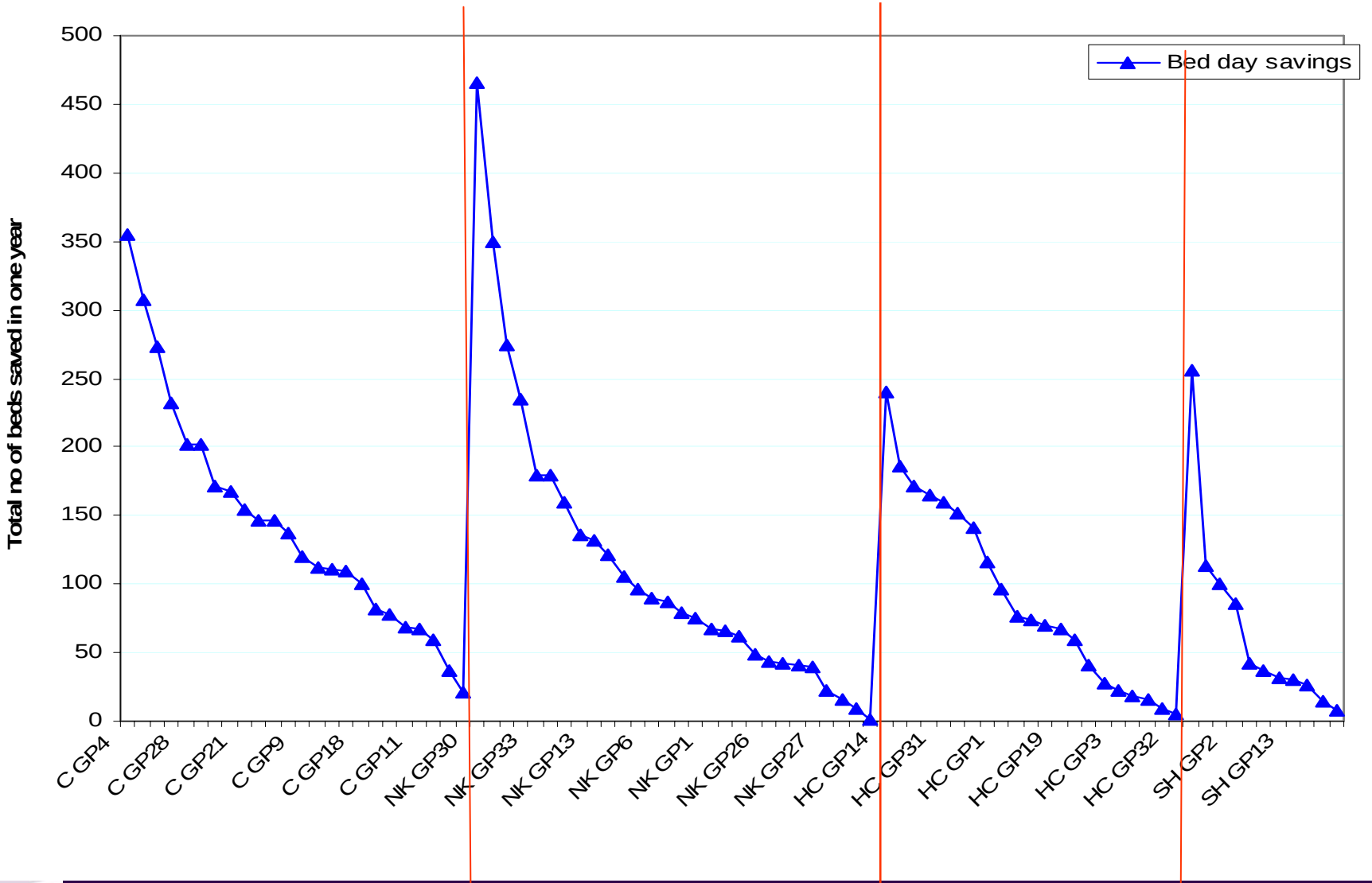
Calderdale PCT

North Kirklees PCT

Huddersfield Central PCT

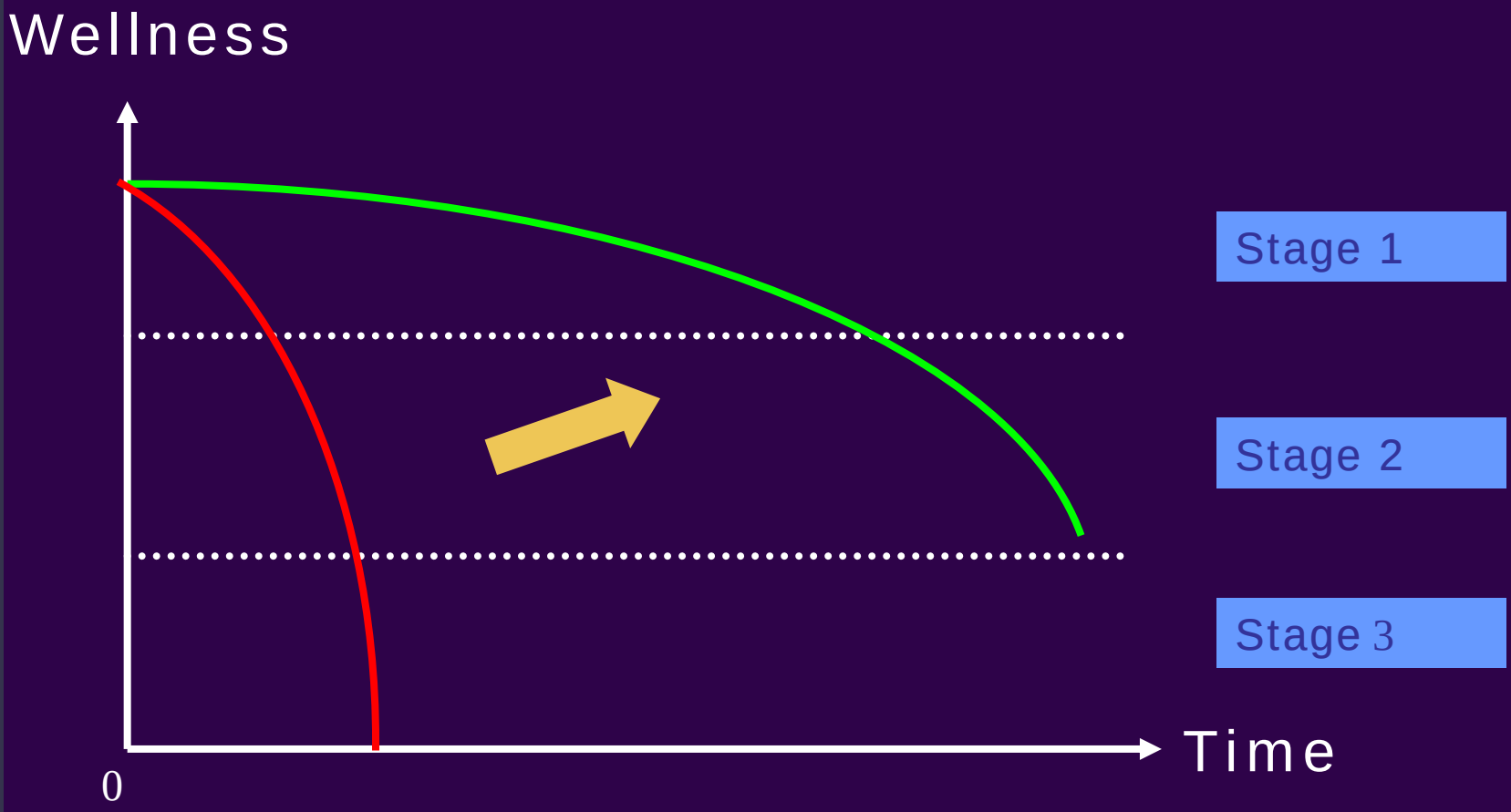
South Huddersfield PCT

Total number of respiratory bed days that could have been saved by GP practice (2003-2004)



Calderdale PCT | North Kirklees PCT | Huddersfield Central PCT | South Huddersfield PCT

Characteristics of Long-term Conditions



Issues

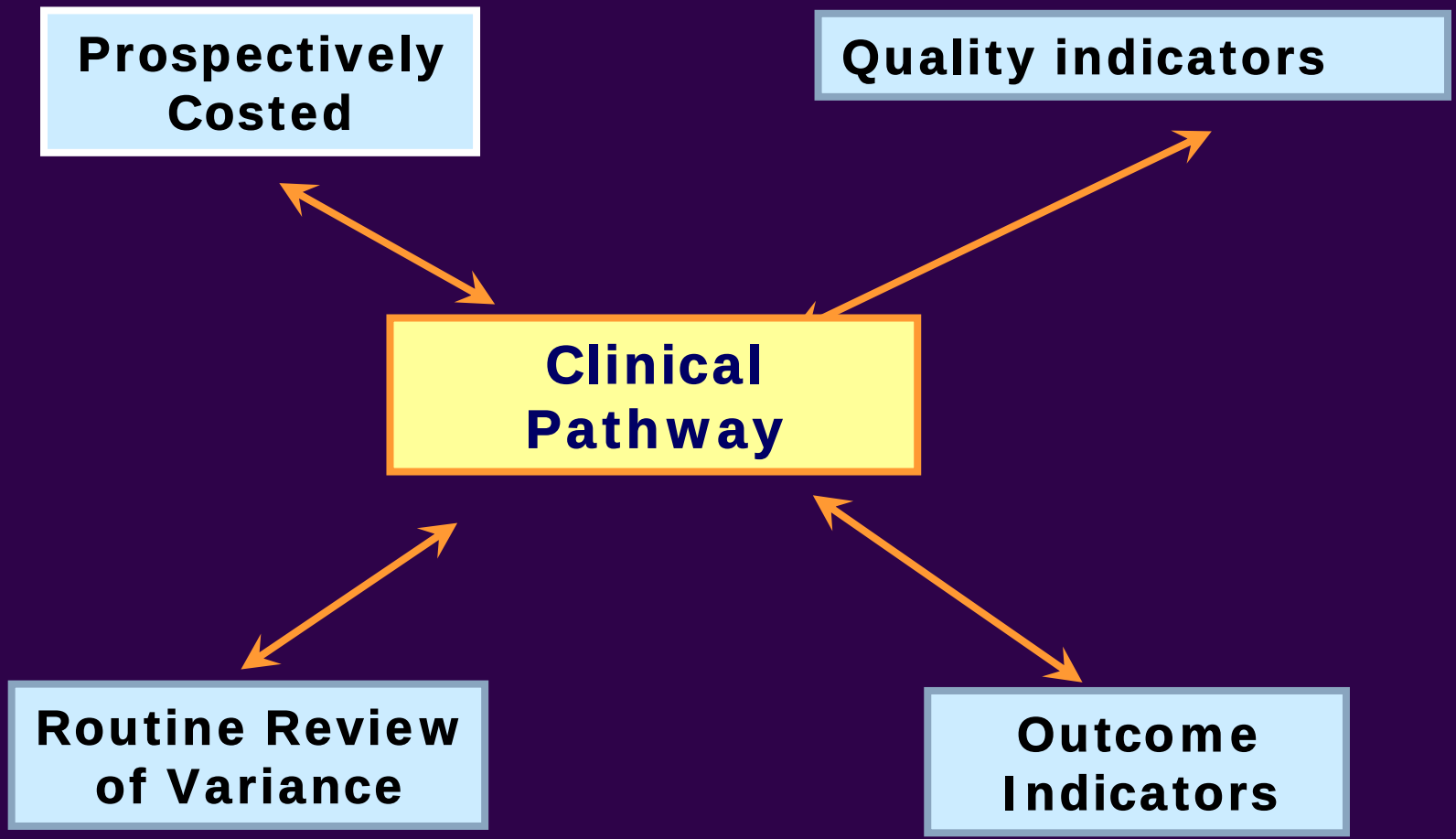
- **Can we affect the rate of disease progression?** Yes
- **Who is best placed to do this?** Primary care working in conjunction with acute care and social care
- **What do we require to bring it off?** 'Year of care pathway'

Requires …

Year of care pathways that, for each stage of disease progression (stage 1,2, 3 …),

- **describe the cycles (weekly/monthly) of ‘care activities’**
- **that will be undertaken by ‘patients’ and service providers**
- **in the period of a year**

Characteristics of year of care pathways for each stage of disease progression



Year of Care Pathways for LTC

- A comprehensive systematically developed written statement
- that for each stage of disease progression,
- specifies the cycles of events in self care, primary, and community settings
- whose occurrence or non occurrence will significantly affect, quality, outcomes and cost.

Defining features of a year of care pathway

- Emphasis on supporting patients to self-manage their care
- Specified time based cycles within a year
- Events and activities within each cycle tailored to the stage of disease progression and stated resource constraints

Components of a ‘Year of Care’

- **Clinical management**
  - **Diagnostic/Monitoring**
  - **Drugs**
  - **Therapy**
- **Self-management**
  - **Emphasis on empowerment (not a patient but a person with a long term condition) who is a:**
    - **co-producer and**
    - **choice maker**
- **Support Component**

Co-production …

Co-producing people with long term conditions are people who take responsibility for managing their condition with respect to:

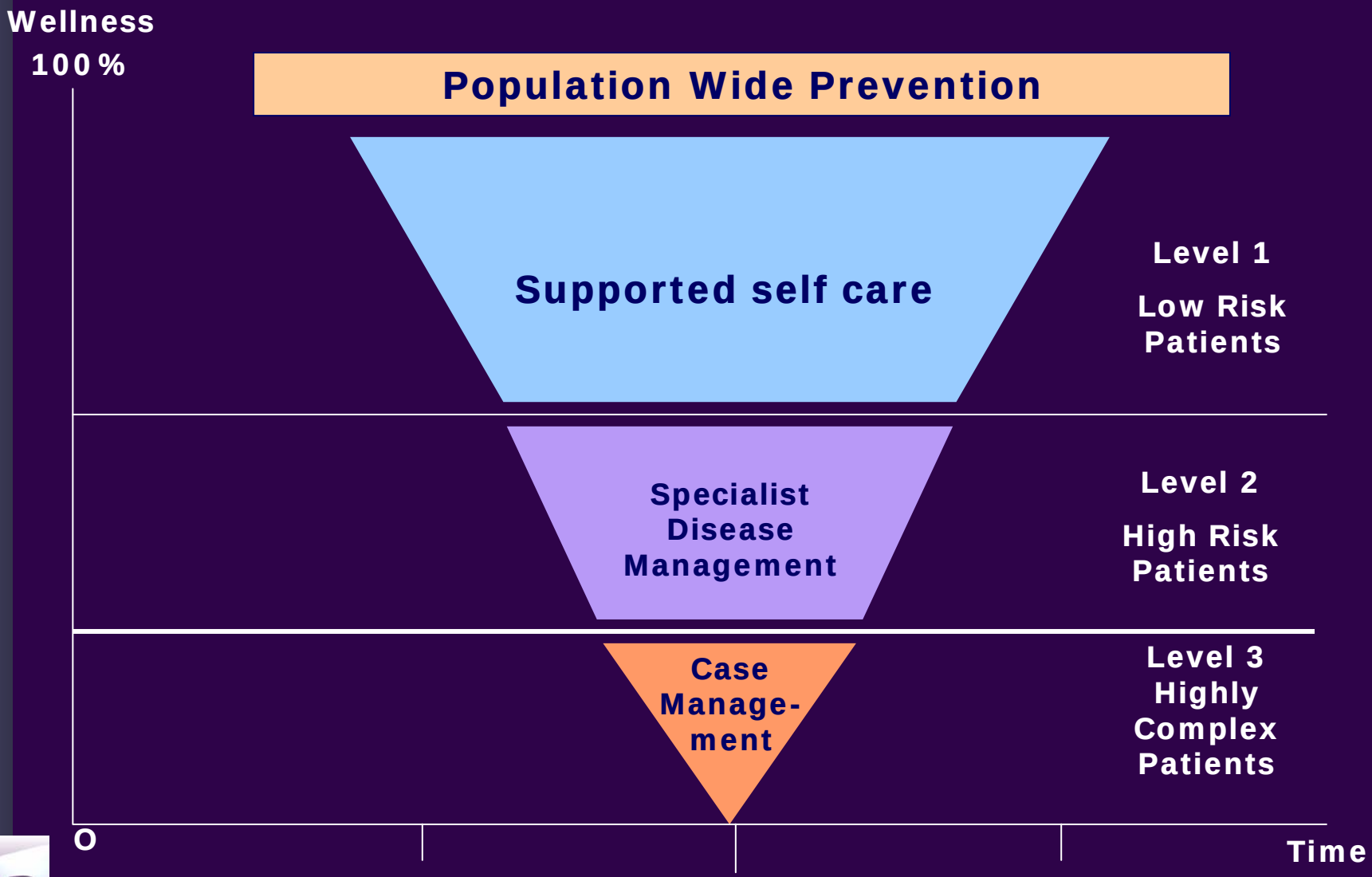
- **Knowledge of their disease**
- **Self monitoring**
- **Therapeutic interventions**
- **Diet**
- **Exercise**
- **Smoking**

Paradoxically: this requires structured support from service providers (often working from within different settings)

Co-production and disease progression …

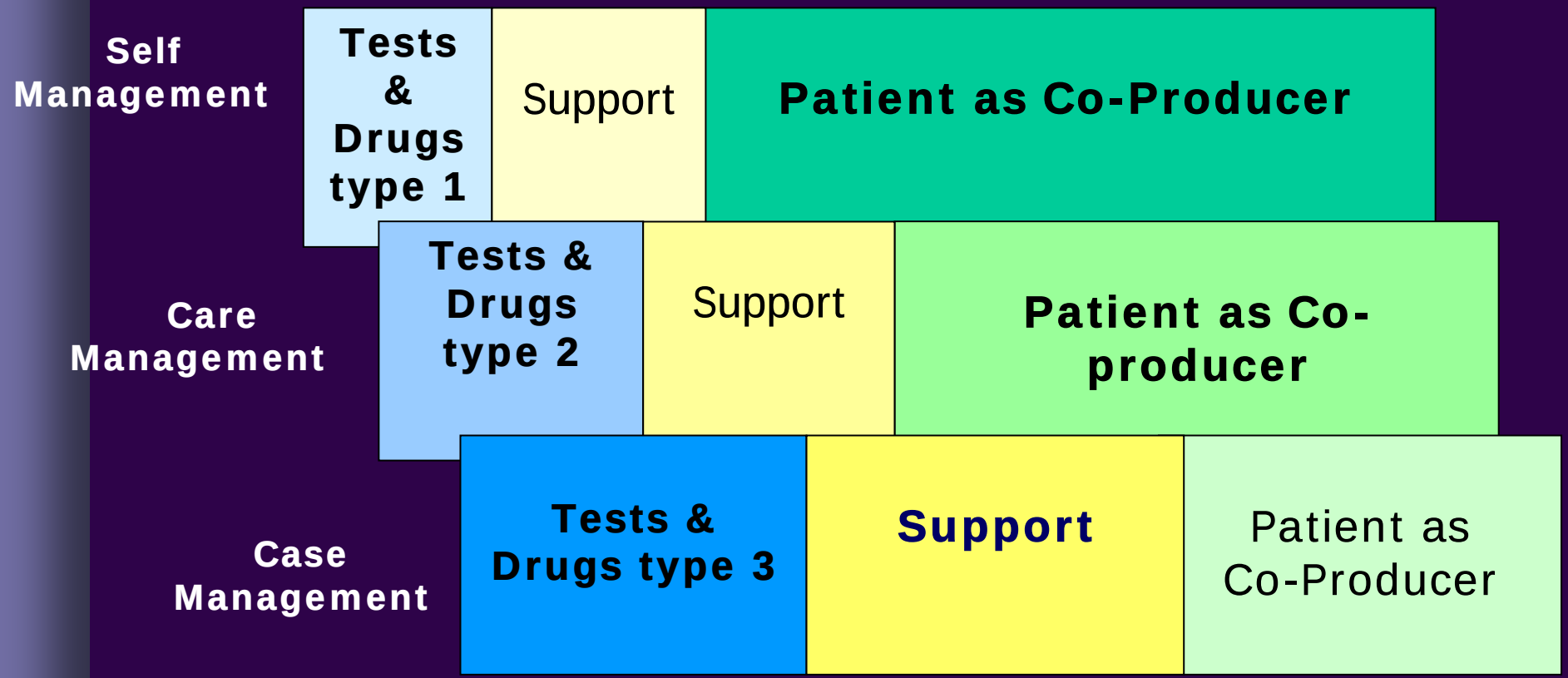
- The extent and nature of an individual's co-producing role will vary depending on the stage to which their disease has progressed
- Hence need to identify the key indicators (clinical, social, psychological) that characterise each stage of a disease progression
- These indicators can then be used to the benefit of:
  - early identification and registration of target populations
  - clarifying an individual's location on the disease trajectory
  - developing and implementing of year of care pathways that are tailored to maximise
    - clinical effectiveness (as measured by a reduced rate of disease progression),
    - quality of life
    - resource efficiency

Disease Progression & Management Sub-Groups



Source: NHS, May 2004

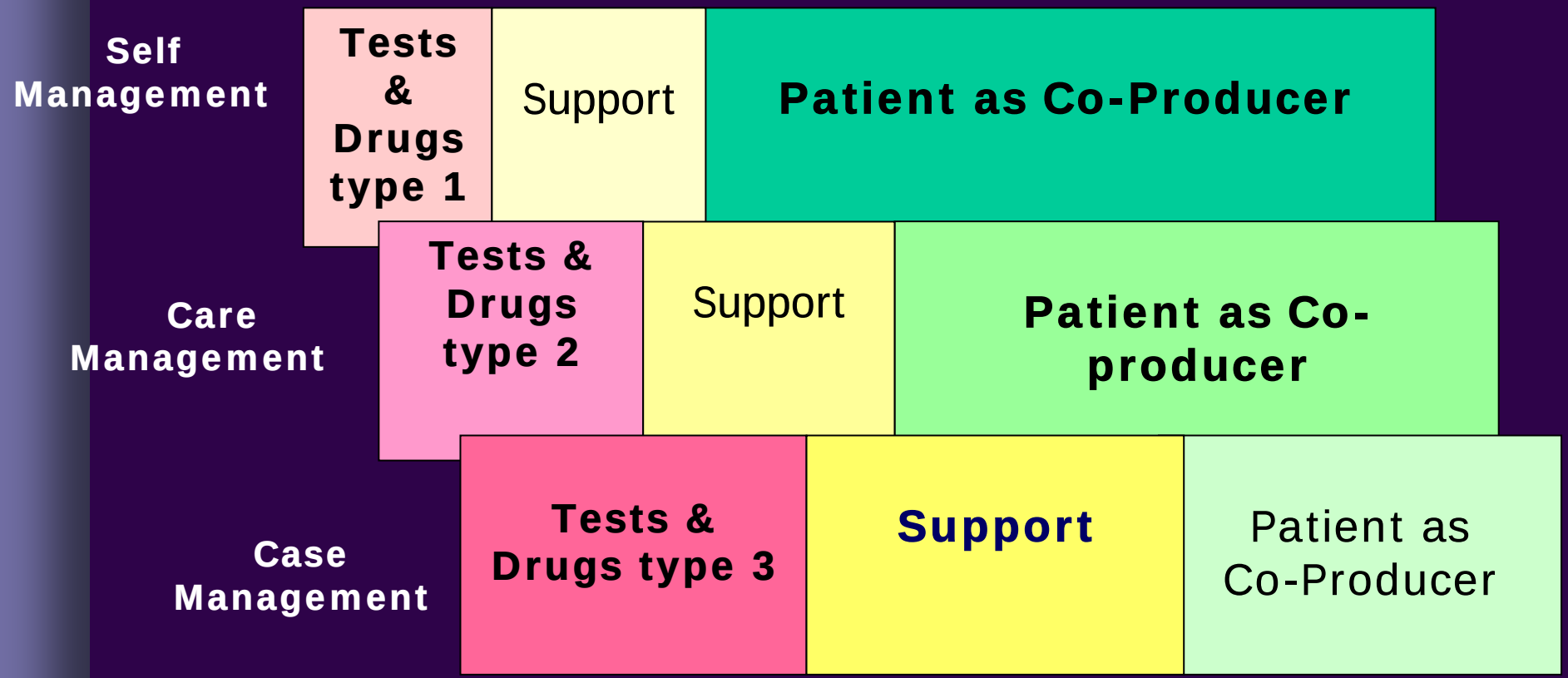
Possible ‘Year of Care’ Models for CHD



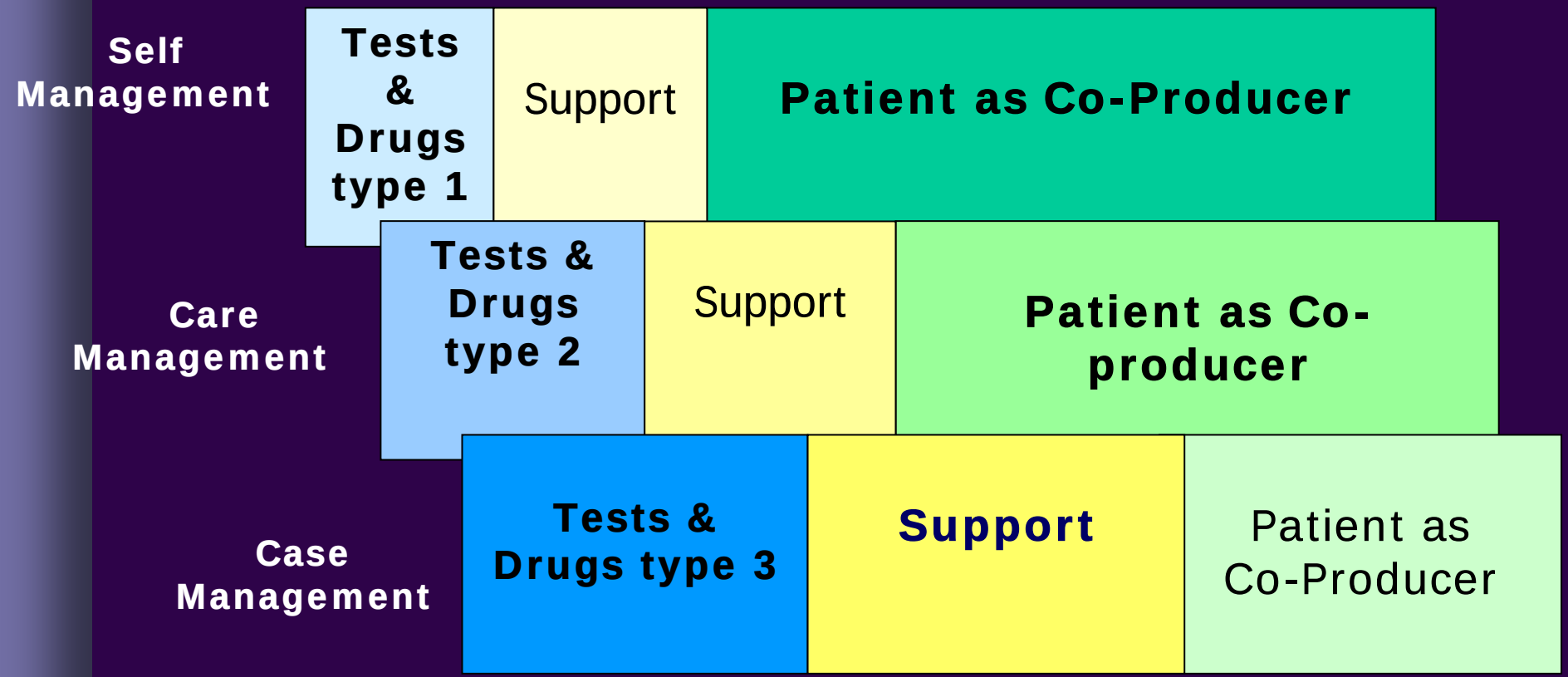
Issues to be answered on implementing ‘year of care’

- Development of criteria for stratifying patients on disease progression
- Specification of characteristics of each element of the ‘year of care’ for each stage of disease progression
- Authorisation of ‘year of care’ model across primary and acute care – (dis)incentives of profession, contract, regulatory, organisational mechanisms
- Identification of factors (social, psychological, cultural, organisational and funding) that may facilitate or impede realisation of co-producer and development of strategies to address these
- IT issues - social aspects, data ownership (won’t be solved by PfIT)
- System issues ie how do we avoid creating new silos

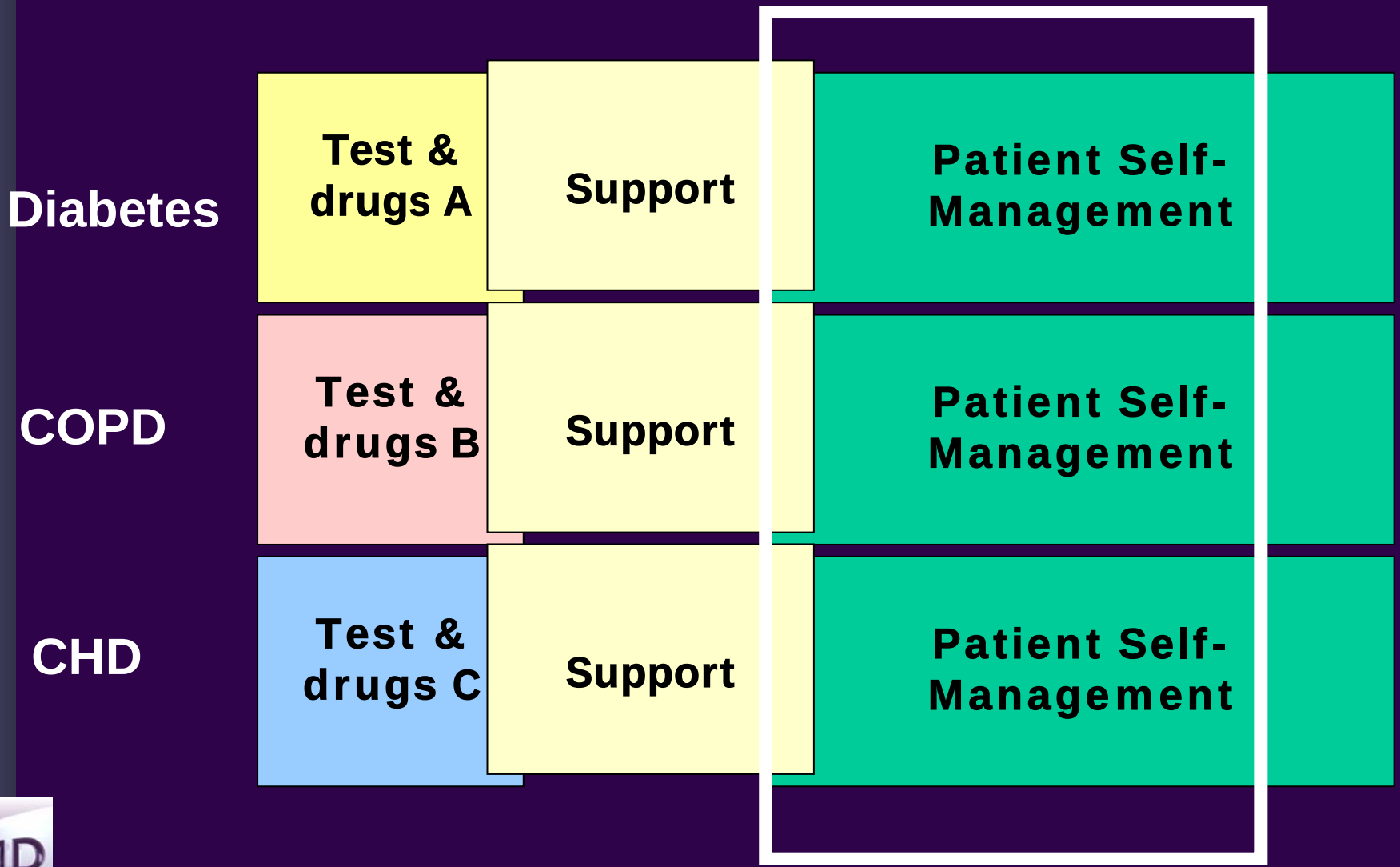
A ‘Year of Care Model’ for COPD



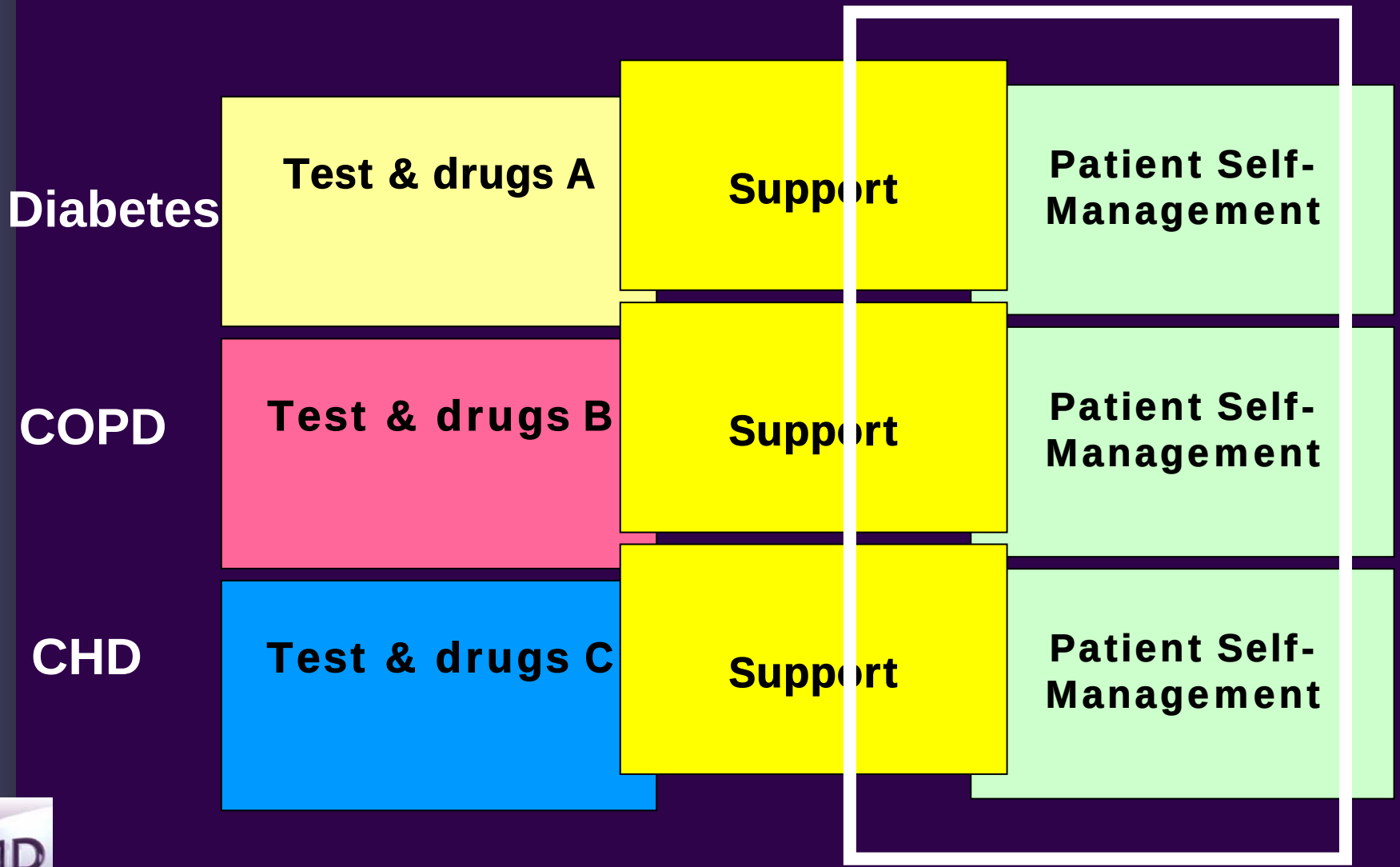
Possible ‘Year of Care’ Models for CHD



Commonalities of Care - Stage 1



Commonalities of Care - Stage 3



More questions to be answered on implementing ‘year of care’

- What structures and processes need to be put in place across PCTs and Acute trusts to authorise use of year of care pathways and to monitor performance?
- What are the workforce development implications?
- How do we move from where we are to where we want to be?

Advantages of year of care model

The model provides a basis for:

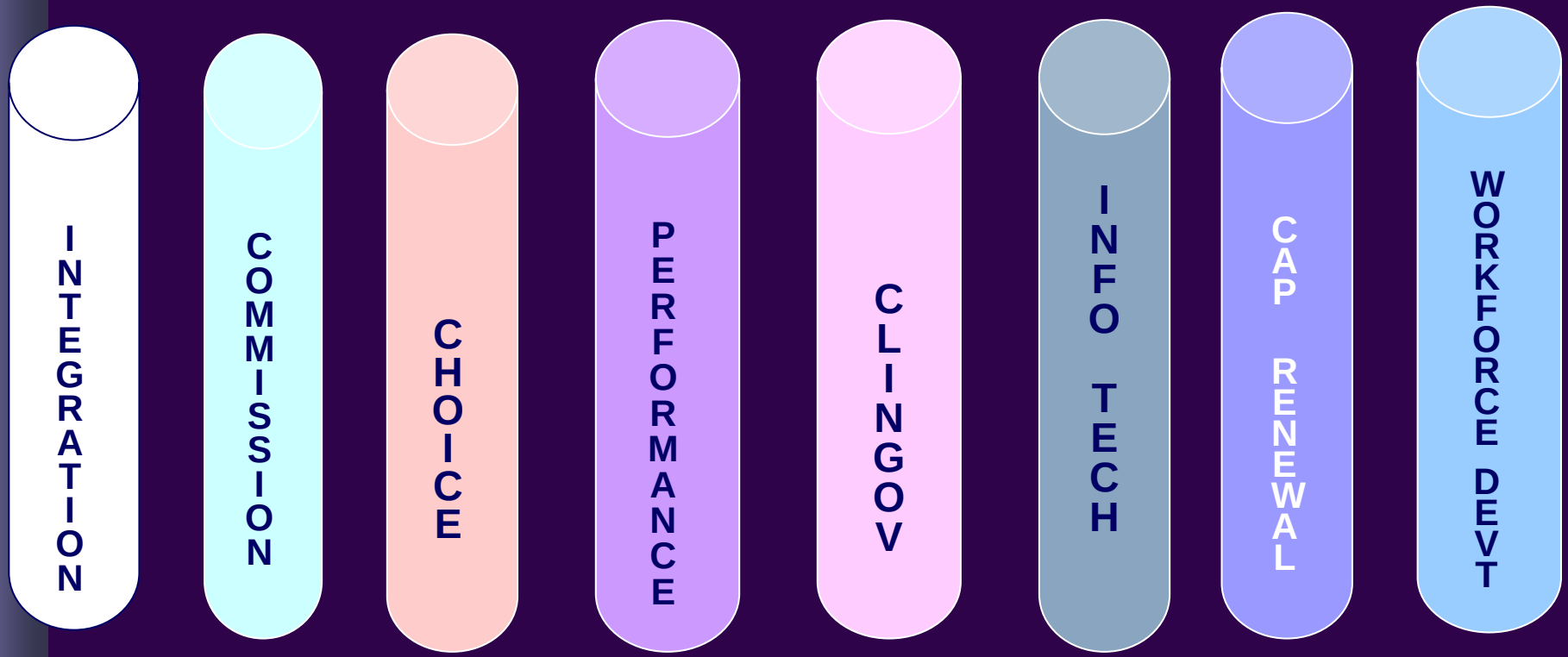
- stratifying individuals on specified clinical, personal and social criteria
- describing and hence materialising the contributions of co-producers and service providers within a nominated time frame (i.e who will do what, where and when)
- specifying the contract between co-producers and service providers
- integrating care provision between acute and primary care and

  specifying the support services required for realising co-production
- specifying how these services will be funded (vouchers?)

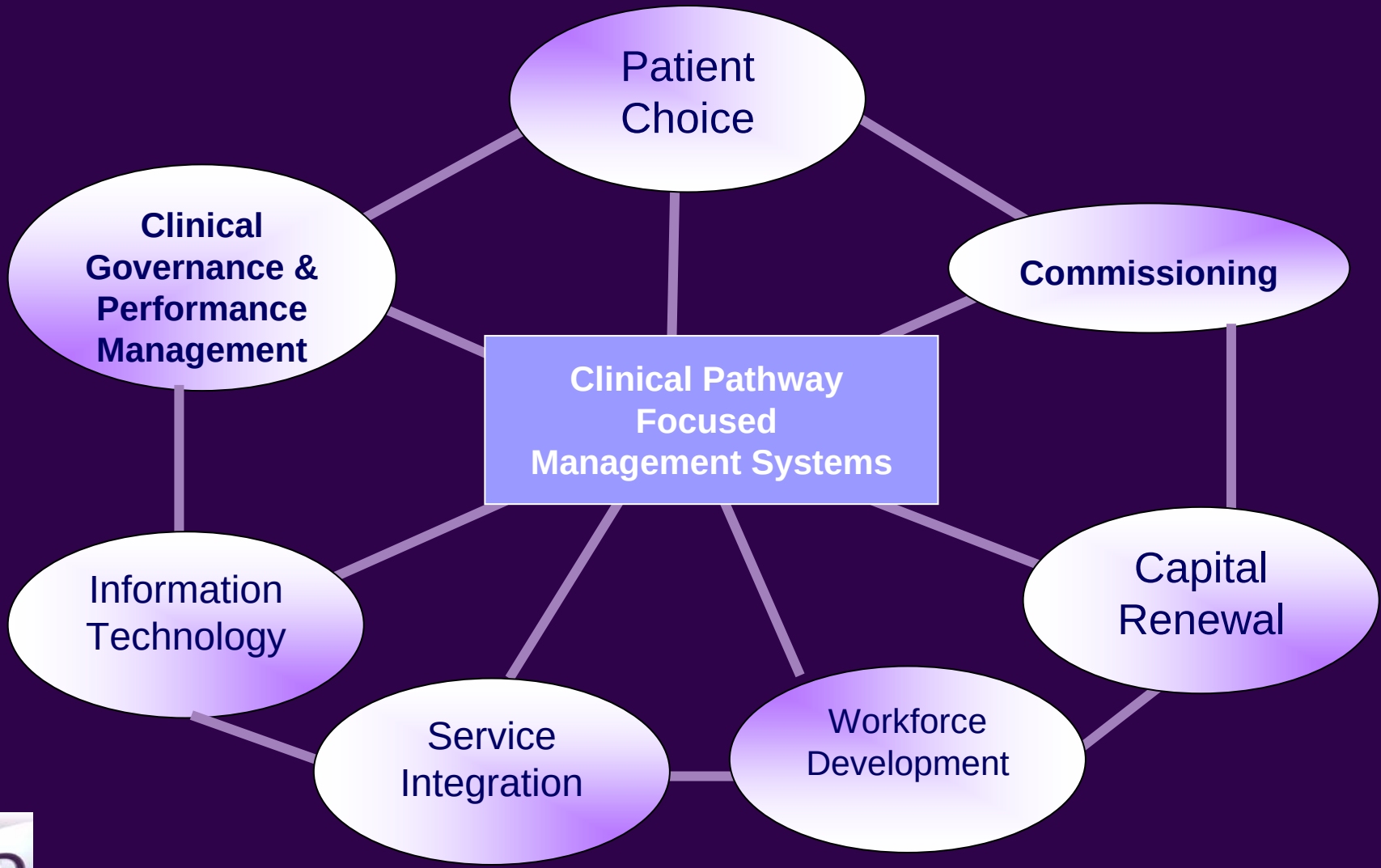
Advantages cont:

- Prospectively costing the pathway in question
- Specifying quality and outcome indicators
- Monitoring performance with respect to the occurrence and non occurrence of specified events
- Identifying (via variance analysis) where improvements can and need to be made
- Benchmarking across health economies

Instead of silos…



Pathways as mediums for integrating the policy agenda



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