Primary care improvement case study

Taumarunui Community Kokiri Trust: He Mate Huka Oranga – a project to keep well with diabetes

Number 9 in a series of 18

Project overview

Taumarunui Community Kokiri Trust (TCKT) is a kaupapa Māori health and social services provider. We deliver holistic care following a whānau ora approach, underpinned by kaupapa Māori values. Our disease state management (DSM) nursing service supports whānau to self-manage medical conditions through health promotion, health and disability service coordination, Māori housing repairs and maintenance, and Pou Hākinakina (healthy lifestyle) programmes.

Our DSM service identified that many of the community's whānau who weren't engaged with any health services also had type 2 diabetes. Accessing services through a general practice can be a barrier for many whānau. We developed a programme to deliver a weekly education and support clinic through a Diabetes Support Group in a community setting, which was open to anyone, whether they were a TCKT client or not. The clinic has given our whānau the confidence to take control of their own health and talk to their general practitioner (GP) about what they want for themselves, and their diabetes control has also improved. We named our project He Mate Huka Oranga, meaning 'keeping well with diabetes', reflecting the aim of our mahi.

Background and context

TCKT was established in 1989 to advance the holistic development and wellbeing of Māori and Pacific peoples, hapū and iwi by delivering comprehensive health and social support services to the communities of central and rural Taumarunui and Te Kuiti. TCKT is a kaupapa Māori health and social services provider. It has strong working relationships with all the iwi that are present in Taumarunui including Whanganui iwi (Te Atihaunui a Paparangi), Ngāti Maniapoto and Ngāti Tūwharetoa.

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa
newzealand.govt.nz
Taumarunui Community Kokiri Trust

TCKT works across the Waikato District Health Board (DHB) in the Ruapehu and Waitomo local government areas with a total of 6,775 enrolled patients in our three clinics based in Taumarunui and Te Kuiti. One of our services is the whānau or mobile chronic DSM nursing service. This is a professional health care service with a tikanga Māori approach to help whānau to self-manage their illness and improve their wellbeing.

Our clinics are designated Very Low Cost Access. A high proportion of our enrolled population consists of high needs patients: 73 percent are living in quintile 4 and 5 (low-income) areas, many of which are also rural and isolated. In addition, levels of education are typically low and unemployment is almost double the national rate.

Of those aged 45+ years in our enrolled population, 7.5 percent (506) are registered with diabetes. Within this group, 52 percent are Māori.

Diagnosing the problem

1 Problem statement

Diabetes is the largest and fastest-growing health issue New Zealand faces and is closely linked to heart disease.

2 How did you know that this is a problem?

The Health Quality & Safety Commission updated the New Zealand Atlas of Healthcare Variation's diabetes domain in 2016, which shows the prevalence of diabetes is increasing. Inequities are also evident as Māori and Pacific peoples with diabetes experience three times as many diabetes related hospital admissions as non-Māori and non-Pacific peoples.

In the Waikato region, the 2013 census indicates that the total population is 403,638, of whom 83,742 are Māori.

Out of the 16 regions in New Zealand, the total population of Waikato is the fourth largest and the Māori population has been second largest, although new estimates indicate that it is now the largest. A total of 21,767 people in Waikato are classified as having diabetes.

The prevalence of diabetes for both Māori and Pacific peoples within the Waikato DHB region highlighted that these people were less likely to actively engage in effective management of their diabetes.

3 What was the baseline data?

A baseline survey of 142 participants in May 2019 found that:

- 95 participants were Māori and 1 was of Pacific ethnicity
- 25 Māori and 1 Pacific participant wanted to attend education programmes in a community setting
- 33 Māori and 1 Pacific participant wanted more education
- 16 Māori and 1 Pacific participant wanted support in a community setting
- 4 Māori participants felt blamed or judged because of their diabetes.

The (SMART) aim

This project aimed to decrease HbA1c to < 45 mmol/L (from the current range of 46–110 mmol/L) for two or more Māori and Pacific patients out of the 26 patients (of a mixture of ethnicities) enrolled in the DSM nursing service by March 2020.

The measures:

Outcome measure:

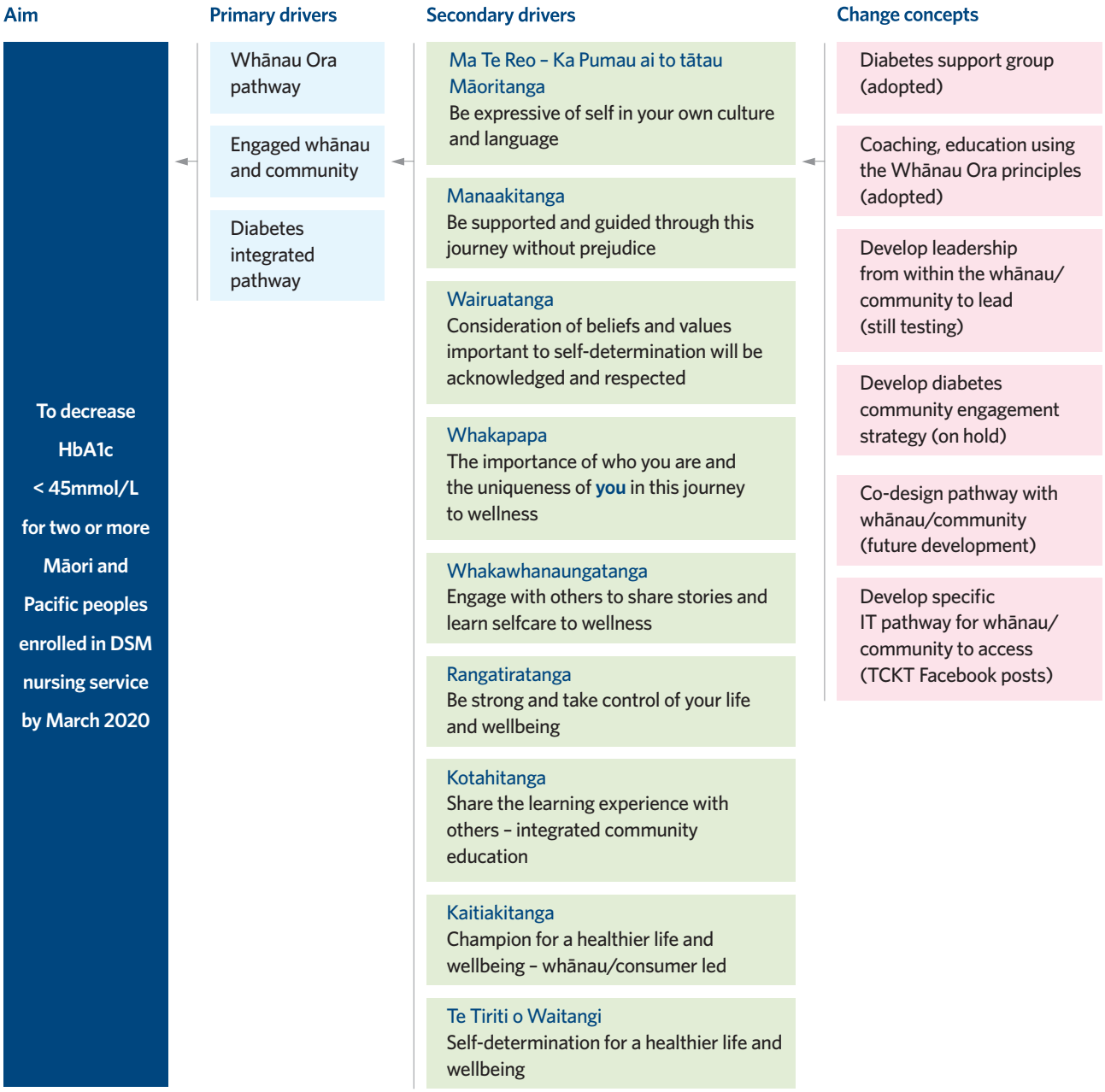
- Number of Māori and Pacific patients with HbA1c below 45 mmol/L (using a manual audit of clinical files to collect this data).

Process measure:

- The number of people attending the Diabetes Support Group sessions (using the attendance register to collect this data).

Drivers of change

Driver diagram



Our tests of change mainly centred on the use of the secondary drivers, which are the principles of te ao Māori that underpin our organisational way of working. This final version of our driver diagram identifies the change ideas that we have adopted.

What did we do?

1 Were there any ethical considerations to be aware of?

No special ethical considerations were required. The project followed the normal practice of keeping patients fully informed and obtaining their informed consent for any changes. The planned changes were evidence-based best practice.

2 What aspects of the project were co-designed with consumers? How did you involve consumers in co-design? What processes did you use?

Consumers were involved in the co-design of:

- the Diabetes Support Group
- coaching and education
- HbA1c odometer tool.

To involve them in the co-design, we:

- conducted an initial community survey
- developed consumer relationships through education and coaching, which increased their understanding of diabetes and led them to get involved in the project
- surveyed the whānau who attended the support group for ideas on how to improve the group so that it met their needs (see Appendix 1 for the survey)
- captured the whānau experience through the whānau ora pathway evaluation process and wānanga. Listening to the whole story of the whānau experience is the way of te ao Māori.

Capturing the patient experience

Waru is a 74-year-old koroheke with a 46-year history of type 2 diabetes. He wants to:

- live into his 90s
- understand the value of food and physical fitness
- enjoy life and whānau.

Marama is a 65-year-old kuia with a 25-year history of uncontrolled diabetes. She wants to:

- be confident in decision-making
- improve and enrich her lifestyle
- participate more in the community.

What whānau and consumers said before and after:

- 'I didn't understand anything about diabetes except it was gonna kill me.'
- Before the project, they had conflicting information on treatment from medical professionals; and were concerned about advertising of food products, where everything is in your face and they felt it was not right.
- 'Pleased to know the Diabetes Support Group has started so I can learn more about how to take care of myself and whānau.'

For whānau and consumers, factors that are critical to quality are:

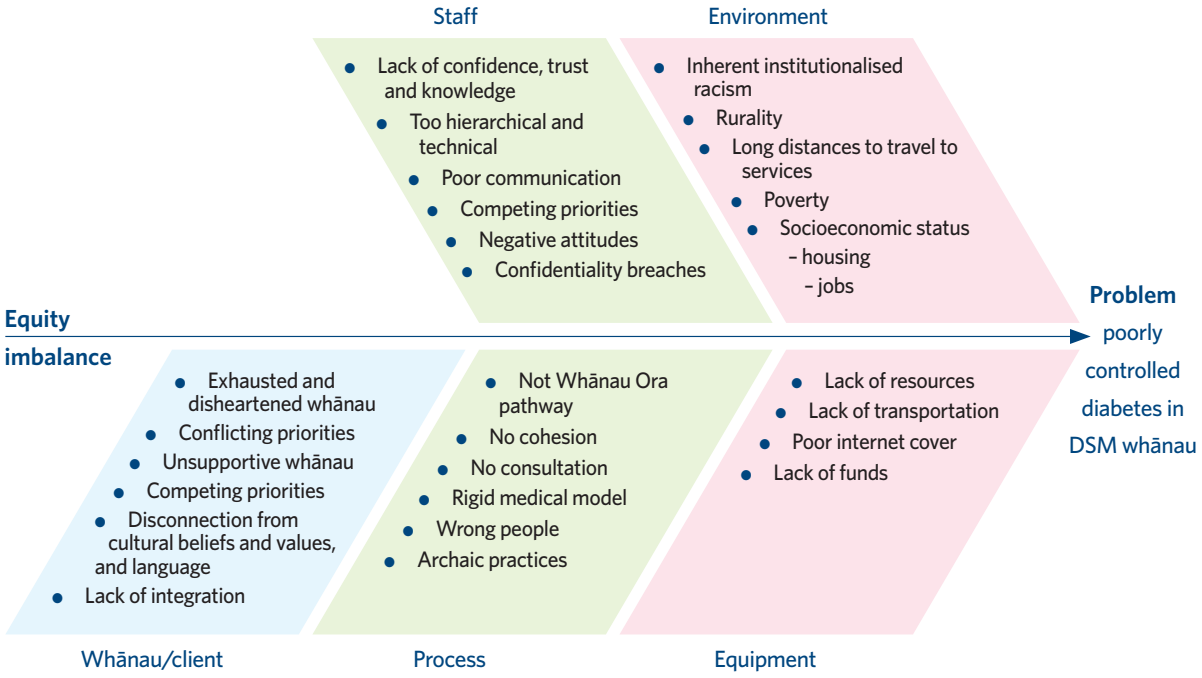
- having continuity in treatment and care
- knowing that someone 'cares about me'
- having information that is relevant and up to date and being supported on this journey.

What QI tools did you use, that you would recommend?

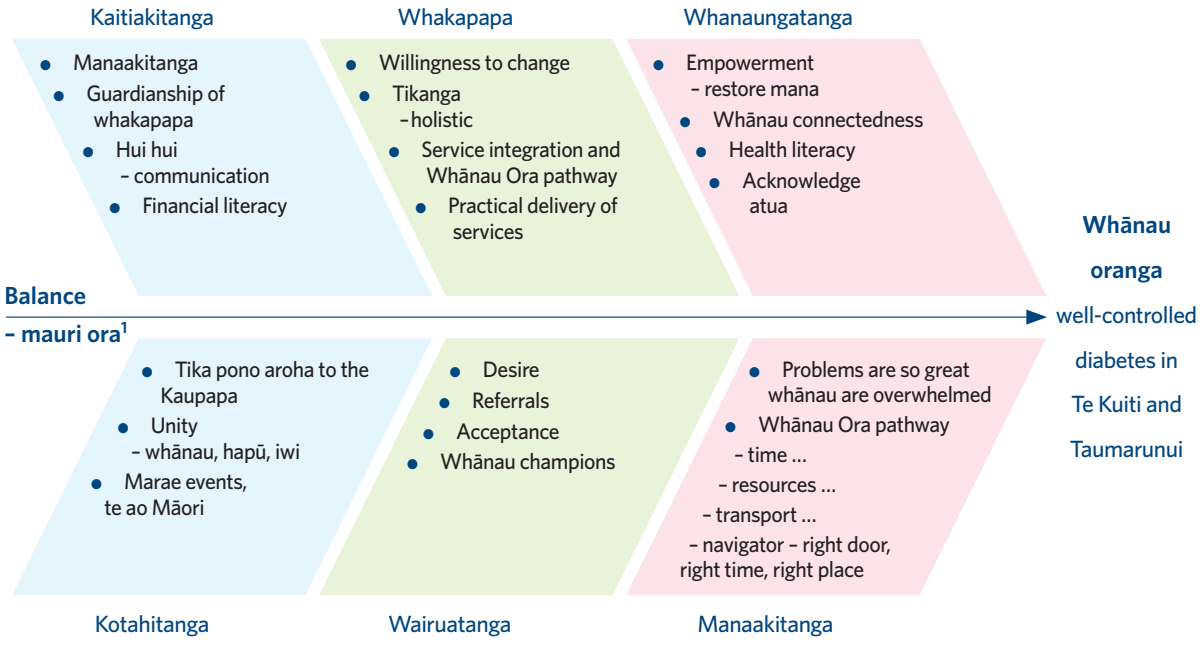
Fishbone diagram

We found fishbone diagrams have been useful to communicate with other service providers and to help them start conversations with their clients.

Problems exposed fishbone diagram



Potential solutions fishbone diagram



1 Maintain the mana of the person you're working with

What changes did you test that worked?

Diabetes Support Group

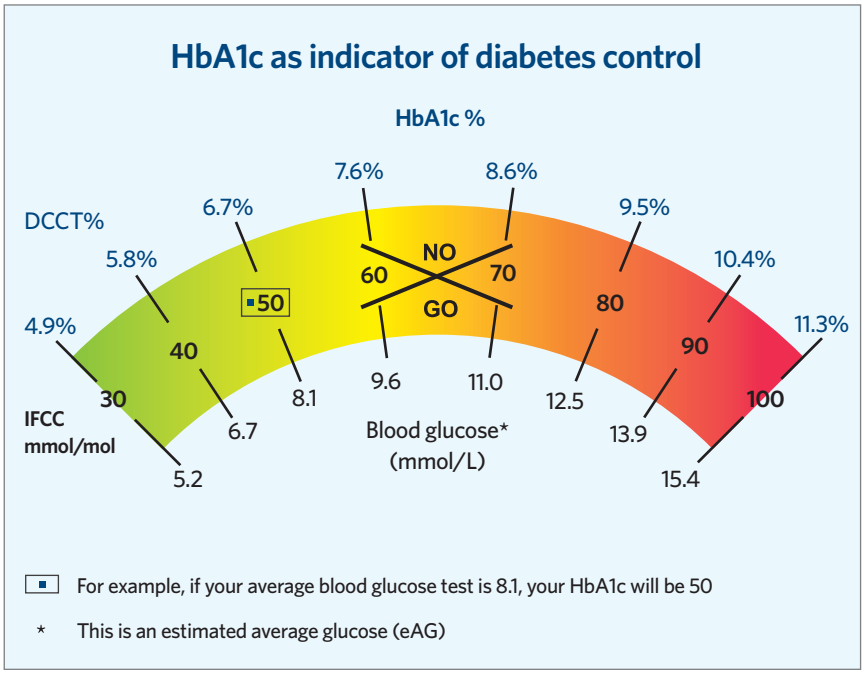
We developed a Diabetes Support Group. Drawing on some initial learnings after we scared away our consumers (see the 'Summary and discussion' section), we got back on track, developed some great relationships and gained the confidence to continue.

We developed a poster to let consumers, other providers and staff know about the support group. Whānau Ora navigators encouraged people to attend and GPs referred patients to it.

Our initial poster was very basic. With consumer feedback, we developed it further so that it was inviting, inspirational and aligned to our kaupapa (see the developed version below).

HbA1c odometer

We used the picture of the HbA1c odometer below to frame the conversation about HbA1c levels with our patients. The patients found this picture easy to understand and could relate to it.

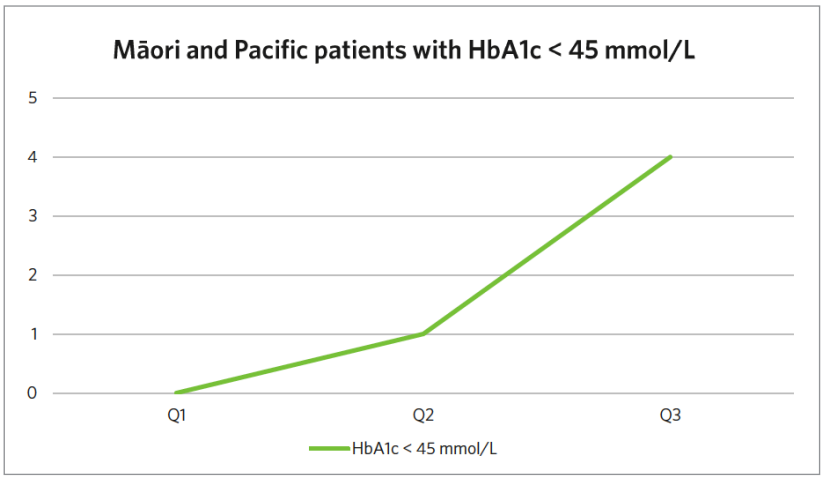


Notes

DCCT%	DCCT = Diabetes Control and Complications Trial
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine Scientific Division
*	This is an estimated average glucose (eAG)
	For example, if your average blood glucose test is 8.1, your HbA1c will be 50

The results

1 What outcome measures improved?

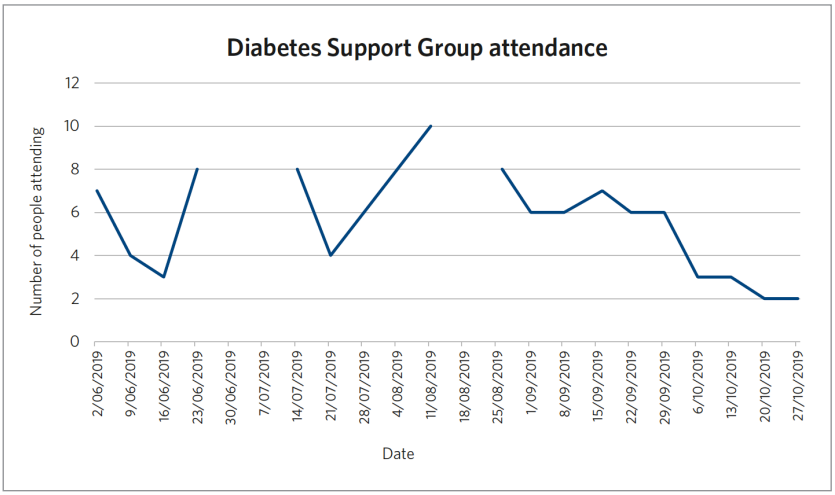


The HbA1c level of four whānau fell below 45 mmol/L in the DSM nursing service during the project.

2 What equity measures improved?

All whānau who saw improvement were of Māori or Pacific ethnicity.

3 What process measures improved?



The following are the key results from our implementation of the Diabetes Support Group.

- The missing data in the chart above indicates scheduled meetings that we were unable to hold.
- Whānau who attended the support group now have a better understanding of what diabetes is, how it has affected their body and what lifestyle changes they need to make. They also understand that type 2 diabetes can be reversed.
- After an initial misstep where we scared our consumers away, the level of attendance at the support group was strong. We learnt that we needed to give consumers control over the content of the group session so that they were invested in attending. Towards the end of the project, the attendance dropped off, partly because consumers gained knowledge and their HbA1c levels improved, and also because some group members moved out of the area.

At support group meetings, the diabetes education and support clinic:

- provided nutritional education in a group setting – food as medicine
- provided resources and tools to reinforce learning
- encouraged physical activity
- addressed weight loss through a focus on wellbeing change rather than on weight loss itself
- introduced a weekly foot and nail clinic and encouraged whānau to attend it as well as specialist appointments
- encouraged whānau to review their health status and needs:
  - with their GP
  - through diabetes annual reviews
  - with a pharmacist.

4 Were there any unintended consequences such as unexpected benefits, problems or costs associated with this project?

The workload involved in undertaking a project on top of usual work was intense and limited family and personal time for the project lead.

5 Is there evidence that the knowledge of quality improvement science in the team or in the wider organisation improved?

We are questioning what we already have in place and whether we can do it better. We have a stronger process focus and can fine-tune our processes so that we are able to deliver a better-quality service to our community.

This project has given the project lead a voice to express and advocate for quality.

Post-project implementation and sustainability

1 Have the successful changes been embedded into day-to-day practice? How have you managed this?

The Diabetes Support Group continues. The practice clinics are beginning to refer people to come to the weekly education sessions.

2 How did you communicate your progress and results to others?

Every morning we have briefings where we share stories, challenges and successes.

We provide quarterly reports to the Ministry of Health.

Summary and discussion

1 What were the lessons learnt?

Initially the nurse educator wanted the community to produce leaders for the Diabetes Support Group. The lesson learnt was that they didn't want to do this as they didn't have the confidence in their own knowledge. They just wanted education on how to reduce their HbA1c levels and how to control their diabetes.

It takes time for the knowledge, behaviour changes and health impacts of such changes to show and be noticed. Leadership cannot be mandated: it occurs naturally out of confidence and self-awareness that builds over time.

2 What would you recommend to a team somewhere else that wants to take on a similar project?

Be patient; have the confidence to trust the people who attend your community groups to grow over time and in their own way.

You really need a foundation of at least two or three other people to bounce ideas off, help with planning and support you on your improvement journey.

Don't be afraid to use the 'trial and error' approach. By simply taking this approach, even if it fails, at least you did something.

3 Are there any future steps or ongoing work that you are intending to continue with on this project topic?

We are still running the Diabetes Support Group, now with an increased focus on wellness through whānau ora principles. For example, we are focusing on 'food as medicine' rather than the disease itself and whānau lead the conversations while staff are instead part of the conversation. As a result, the conversations are about not only diabetes but also whānau priorities such as family or relationship issues and enabling whānau to demonstrate whanaungatanga and manaakitanga in a safe environment.

The team

Other than the nurse educator, the project team membership varied throughout the project due to structural changes and priorities. However, this project would not have been possible without the unwavering engagement and support of organisational leadership.

Appendix 1: Taumarunui Community Kokiri Trust Diabetes Support Group evaluation form

KOKIRI TRUST DIABETES EDUCTION & SUPPORT GROUP EVALUATION FORM

Please complete and return to Aroha

In order to fulfill your expectations, Taumarunui Community Kokiri Trust would like to get your input about this and future events. Please help us by completing the following information.

1 Do you know your HbA1c?

2 What ONE THING did you learn TODAY that you can share with someone else?

3 What can you recommend to improve the information sharing?

4 Would you recommend this support group to someone else?