HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

HUTT UNION & COMMUNITY HEALTH SERVICE

DIABETES IMPROVEMENT PROJECT

October 2017

Project Leads: Sandy Bhawan & Sally Nicholl. Project Team – Rowena Sosich & Kim Baker (GPs), Nita Vaofusi & Leanne Long (Nurses), Tai Pairama & Tria Tamaka (Patient representatives), Mere Te Paki (Community Health Worker), Muriel Tunoho (Governance), Sandy Bhawan (Pharmacist), Sally Nicholl (Manager)

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Problem Analysis

- Hutt Union & Community Health Service has 578 patients with diabetes. Almost 50% of patients have an HbA1c greater than 64mmol/mol, which indicates poor glycaemic control
- The target HbA1c level for people with diabetes is between 50-55mmol/mol
- Evidence shows that for every 10mmol/mol reduction in HbA1c there is a 21% decrease in diabetes related death and significant decreases in other complications

Our aim is to reduce the average Hba1c by 10% in HUCHS patients with diabetes by 31 December 2017

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Theory of Change

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
To reduce the average Hba1c by 10% in HUCHS patients with diabetes by 31 December 2017	Effective diabetes management processes	Clear pathways for patients with diabetes; Individualised patient management plans; Improved integration between providers	• Provide regular data and feedback to providers adopted • Have a consistent pathway for new and existing patients with diabetes testing • Individualise patient management plans testing • Standardise prescribing of diabetes medication • Review patients on pioglitazone after 6 months with no significant reduction in Hba1c adopted • Map external and internal diabetes services and agree referal and feedback processes • Better connection with local community pharmacies
	Barriers to access	Reduce financial barriers; Provide culturally appropriate services; Clinic access	• Check eligiblility for disability allowances and for clinic visits and medications planning • Increase staff knowledge and awareness of cultural issues • Offer extended clinic hours • Transport plans for patients as needed
	Patient empowerment	Patient knowledge; Patient engagement; Community & Whanau partnerships	• Develop education sessions and programmes based on patient feedback –**Pt Experience Survey** testing • Print out Hba1c chart for each patient adopted • Implement Manage My Health patient portal • Patient, whanau and community feedback and co-design adopted • **Sharing patient stories** planning • **HUCHS facebook page** planning • **Patient info sheet** testing • **Diabetes Blood Glucose Monitoring Software** • **Exercise Programme** testing • **"Sticky Blood" Letter** adopted

Measures

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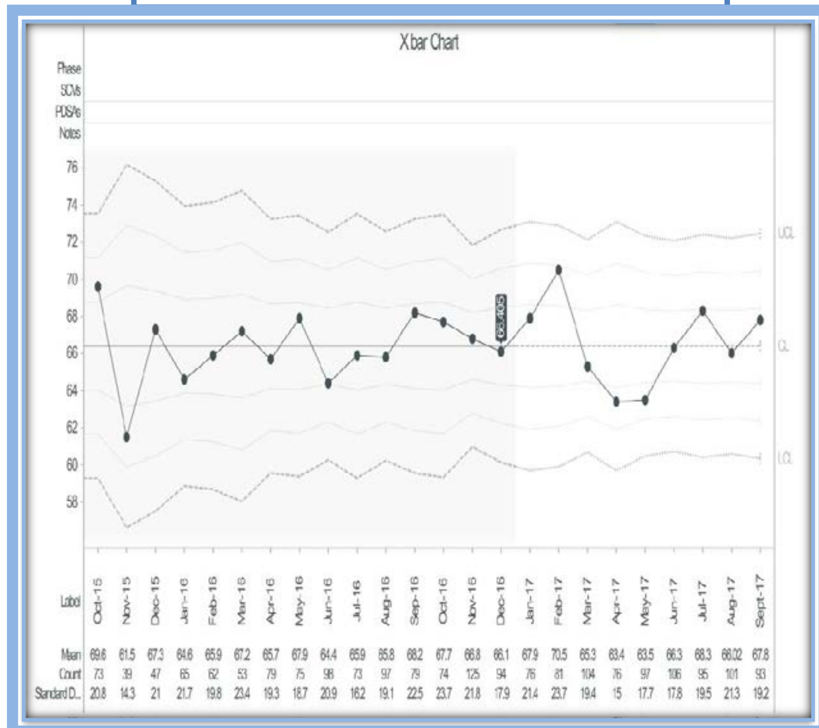
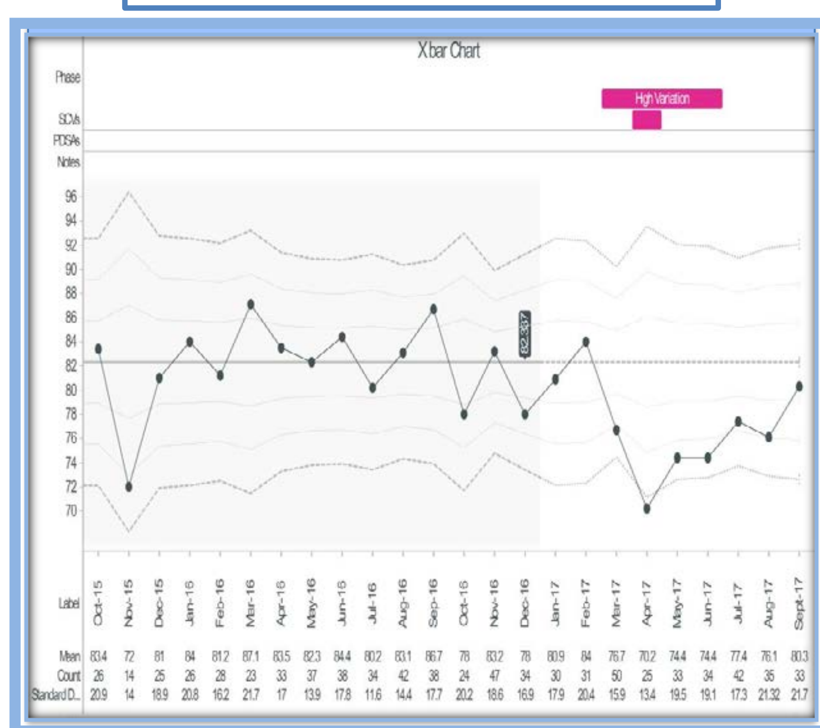
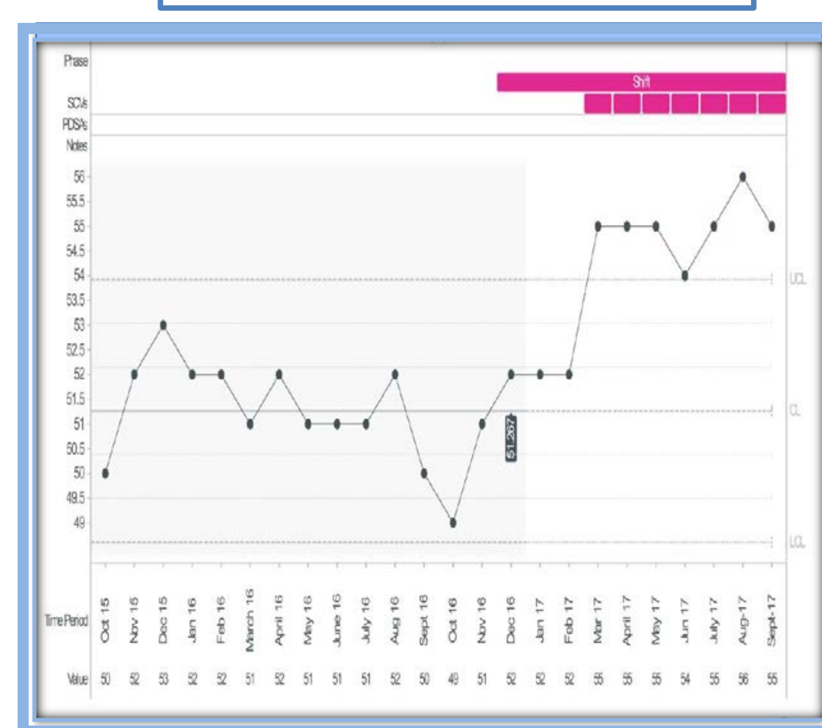
Average Hba1c



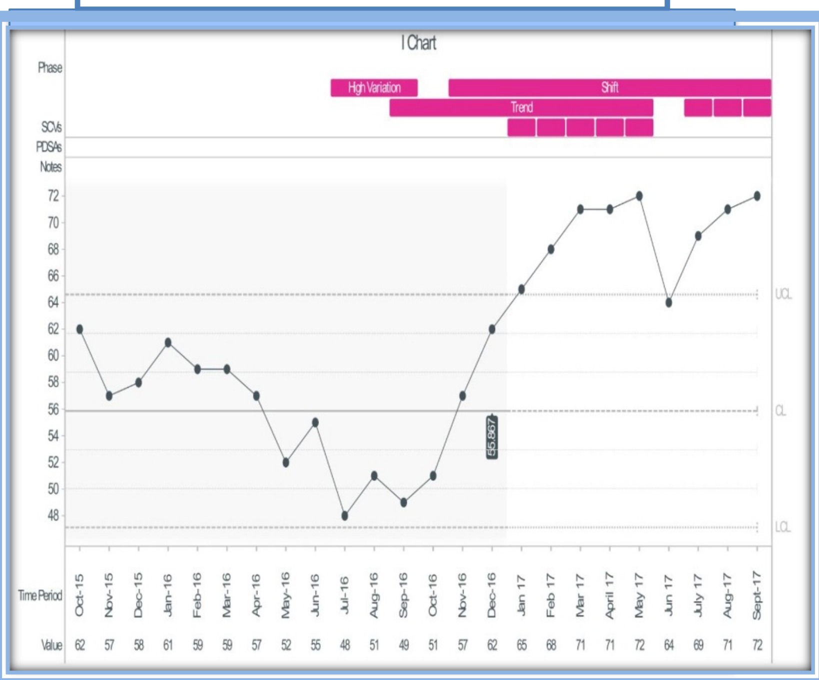
Average Hba1c –Cohort 1



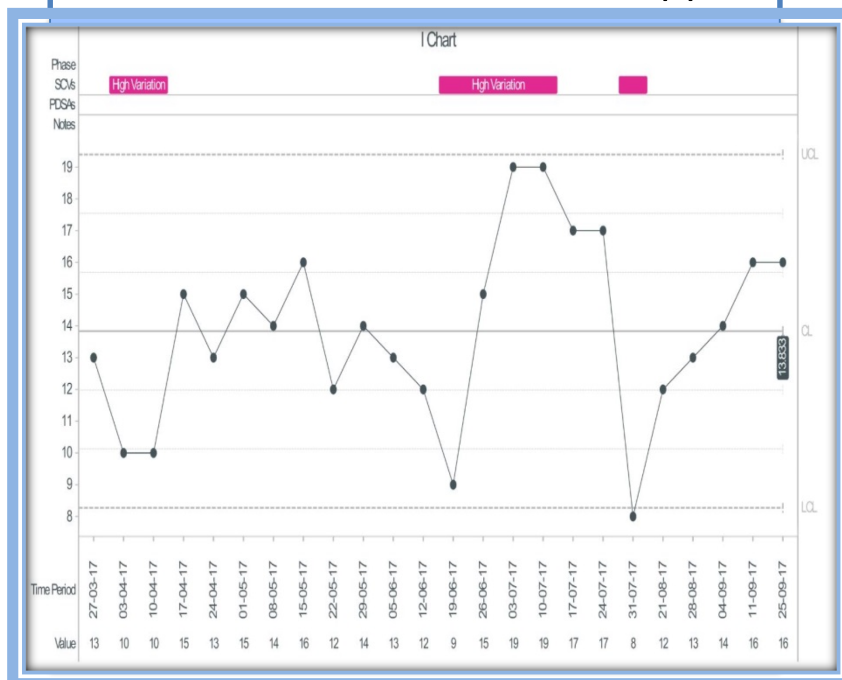
Percentage with Hba1c <65



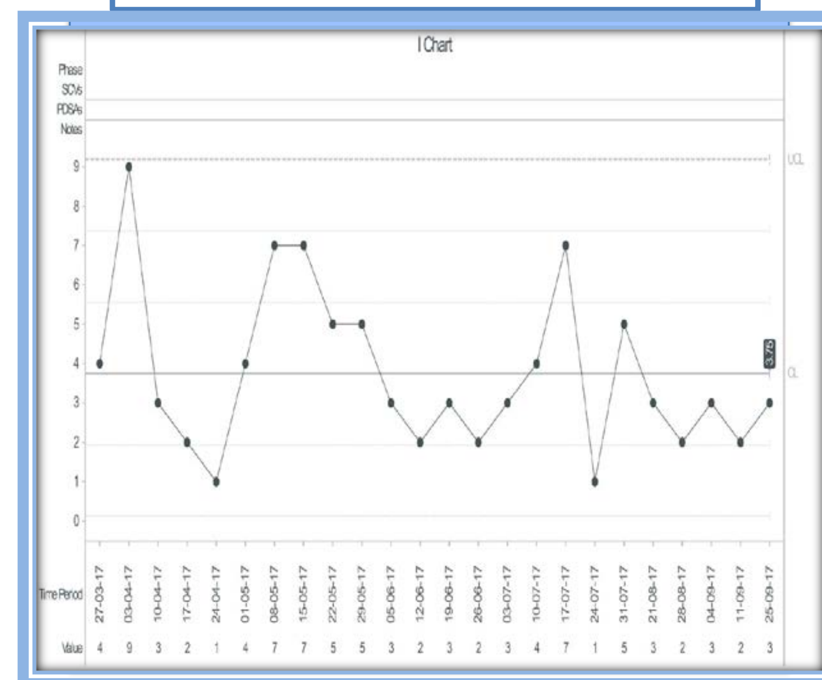
Patients completed DAR



Third next available doctor appt



Third next available nurse appt



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Action Plan October 2017

Work Stream	Task	Timeframe	Responsible
Te Kete Hauora (Consumer Advisory Group)	Fortnightly meetings	Ongoing	Muriel, Tria, Mere, Sandy, Sally
PDSA: Patient Experience Survey	In testing phase, to be given to patients after DAR appointment	31 Oct 2017	Sally/Sandy
PDSA: Patient Information Sheet & Careplan	In testing phase,to be given to patients at DAR appointment	31 Oct 2017	Sally/Sandy
PDSA: Diabetes management pathway	In testing phase, both sites have a laminated copy of the pathway in clinic rooms	31 Oct 2017	Kim, Rowena, Leanne, Nita
PDSA: Sticky blood letter	Adopted, plan to convert to MedTech outbox document	31 Oct 2017	Sandy
PDSA: Disability allowance	Add disability allowance screening to the quarterly data for providers	14 Nov 2017	Sally
PDSA: Blood glucose monitoring	Look at data for pts identified by DH & LL	14 Nov 2017	Sally
PDSA: Facebook page	Plan for diabetes facebook support group	10 Oct 2017	Te Kete Hauora
PDSA: Patient Portal	To be developed	30 Nov 2017	Sally
PDSA: Diabetes exercise class	Planning session completed, first session planned for 26 October	31 October 2017	Colleen & Te Kete Haoura
PDSA: Patient Medication Info Sheet	To be redesigned following pt feedback	30 Nov 2017	Sandy
Feedback to providers	Provide lists to GPs quarterly showing the hba1c of patients with diabetes	Ongoing	Sally
Nurse targets	Monthly feedback to nurses on number of diabetes annual reviews completed	Ongoing	Sally
Monthly reports to HQSC		Ongoing	Sandy/Sally
Monthly storyboard		Ongoing	Sandy/Sally
Monthly measurements		Ongoing	Sally

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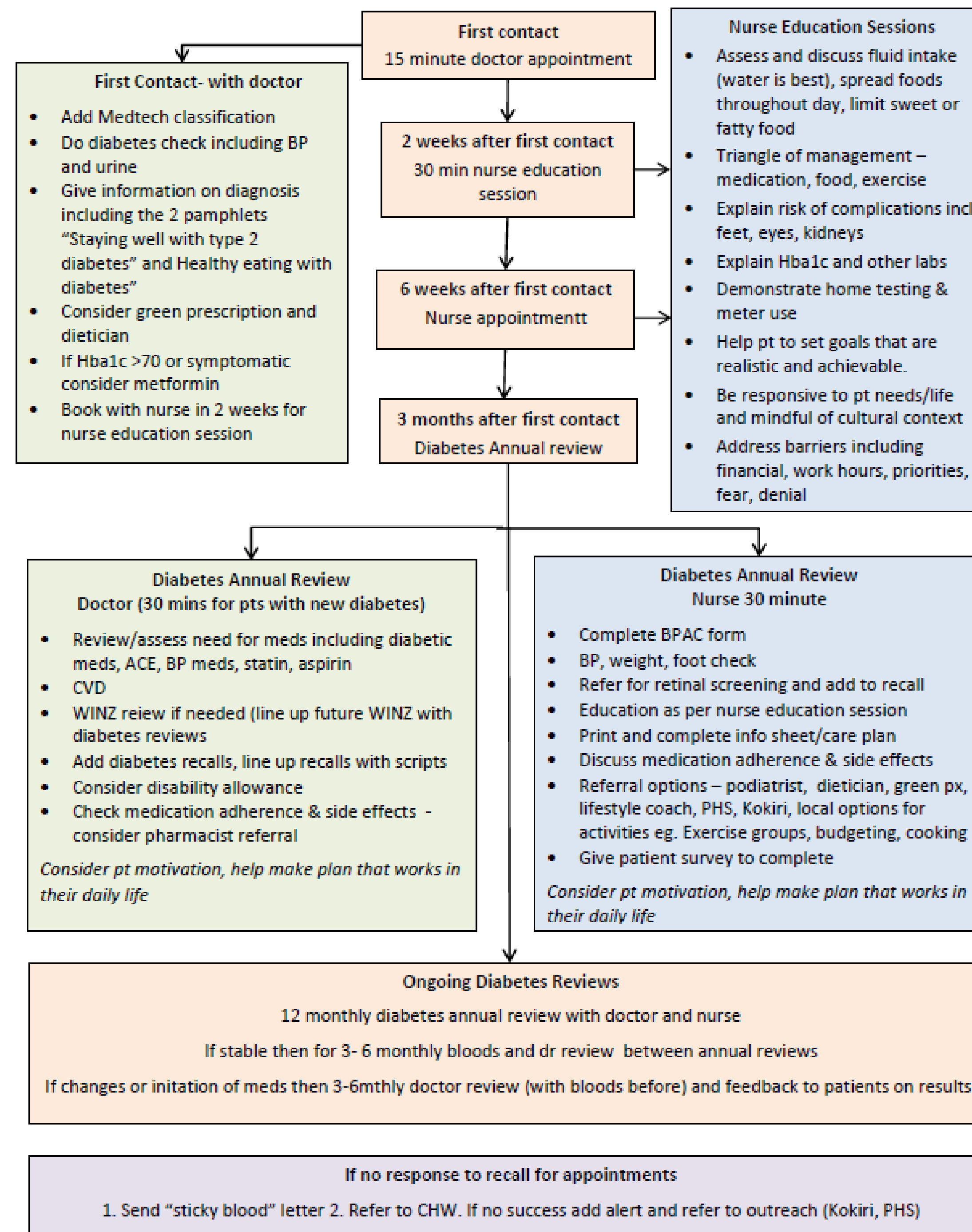
Improving Diabetes Management Processes



HUCHS PATHWAY FOR PATIENTS WITH DIABETES

First contact
15 minute doctor appointment

First Contact- with doctor
- Add Medtech classification
- Do diabetes check including BP and urine
- Give information on diagnosis including the 2 pamphlets "Staying well with type 2 diabetes" and Healthy eating with diabetes"
- Consider green prescription and dietician
- If Hba1c >70 or symptomatic consider metformin
- Book with nurse in 2 weeks for nurse education session

2 weeks after first contact
30 min nurse education session

6 weeks after first contact
Nurse appointmentt

3 months after first contact
Diabetes Annual review

Nurse Education Sessions
- Assess and discuss fluid intake (water is best), spread foods throughout day, limit sweet or fatty food
- Triangle of management – medication, food, exercise
- Explain risk of complications incl feet, eyes, kidneys
- Explain Hba1c and other labs
- Demonstrate home testing & meter use
- Help pt to set goals that are realistic and achievable.
- Be responsive to pt needs/life and mindful of cultural context
- Address barriers including financial, work hours, priorities, fear, denial

Diabetes Annual Review
Doctor (30 mins for pts with new diabetes)
- Review/assess need for meds including diabetic meds, ACE, BP meds, statin, aspirin
- CVD
- WINZ reiew if needed (line up future WINZ with diabetes reviews
- Add diabetes recalls, line up recalls with scripts
- Consider disability allowance
- Check medication adherence & side effects - consider pharmacist referral

Consider pt motivation, help make plan that works in their daily life

Diabetes Annual Review
Nurse 30 minute
- Complete BPAC form
- BP, weight, foot check
- Refer for retinal screening and add to recall
- Education as per nurse education session
- Print and complete info sheet/care plan
- Discuss medication adherence & side effects
- Referral options – podiatrist, dietician, green px, lifestyle coach, PHS, Kokiri, local options for activities eg. Exercise groups, budgeting, cooking
- Give patient survey to complete

Consider pt motivation, help make plan that works in their daily life

Ongoing Diabetes Reviews

12 monthly diabetes annual review with doctor and nurse

If stable then for 3- 6 monthly bloods and dr review between annual reviews

If changes or initation of meds then 3-6mthly doctor review (with bloods before) and feedback to patients on results.

If no response to recall for appointments

1. Send "sticky blood" letter 2. Refer to CHW. If no success add alert and refer to outreach (Kokiri, PHS)

Hutt Union & Community Health Service – Pathway for Patients with Diabetes. September 2017

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Empowering Patients

HUCHS CAREPLAN FOR PATIENTS WITH DIABETES

First Diabetes Appointment

Your doctor will discuss diabetes, healthy eating and exercise and answer any questions you have
It is possible you may be started on medications. The doctor will also give you some written information to take away

Nurse Diabetes Education Sessions

You will be offered two free appointments with the nurse over the next few months. These are an opportunity to understand more about diabetes and ask any questions you or your family have.
Our nurse can help you make a plan for managing your diabetes that fits into your daily life

It can be very helpful to bring other family members to this appointment

Diabetes Annual Review

This is done every year. The first one will usually be done three months after your diagnosis
You will need to go to the lab for a urine and blood test at least 3 daysbefore the appointment.
This is for a check up with the nurse (30 mins) and the doctor (15-30 mins)
They will discuss your blood test results, how you are going with your eating and exercise, and medications if you are on them
They will also refer you to an optometrist for an eye check (retinal screening)

Ongoing Diabetes Appointments and Tests

12 monthly diabetes annual review with doctor and nurse (with blood and urine test before)

3-6 monthly diabetes reviews with the doctor (with blood test before)

2 yearly appointment with the optometrist for an eye check (retinal screening), this may be more frequent if there are any issues with your eyes

Wanting To Know More About Diabetes?

Talk to your doctor or nurse

Talk to our community health workers about exercise and cooking classes in your community

Join the HUCHS diabetes support facebook page

Look at this helpful site http://type2diabetesexplained. co.nz?

Contact Kokiri Marae on 939 7906 or Pacific Health Service on 939 7906

Make an appointment with our pharmacist to discuss your medications

Make an appointment with our dietician to discuss your diet

Name: Mr Mickey Mouse **Date of Plan:** 22 Sep 2017

HEALTH INFORMATION			
Test/Assessment	Reason	Target	You
Hba1c blood test	Shows your average blood sugar level over the last 3 months	50-55	22
ACR- urine protein and creatinine ratio	Tests for kidney function	Less than 2.5 (male) Less than 3.4 (female)	
Blood pressure	Good blood pressure control helps your heart, kidneys and eyes to be healthy	Less than 130/80	120/80
Weight	Maintaining a healthy weight range		78
BMI	Shows height to weight ratio	Less than 30	
Cardiovascular Disease Risk Assessment	To see if you need medication to reduce your risk of heart attacks and strokes	Below 5% means your risk is low	
Retinal screening (2 yrly or more often if needed	Diabetes can cause eye damage		
Podiatry (feet)	Diabetes can cause damage to your feet		
Help to quit smoking	Smoking can increase the risk of complications		

CARE PLAN

- ❒ Exercise
- ❒ Dietician
- ❒ Podiatrist
- ❒ Medication
- ❒ Motivation
- ❒ Disability certificate
- ❒ Pharmacist review
- ❒ Recalls & scripts

Co-Designing