Improving West Coast access to care and the journey for individuals and families with pre-diabetes and diabetes

Primary Care Improvement Facilitators
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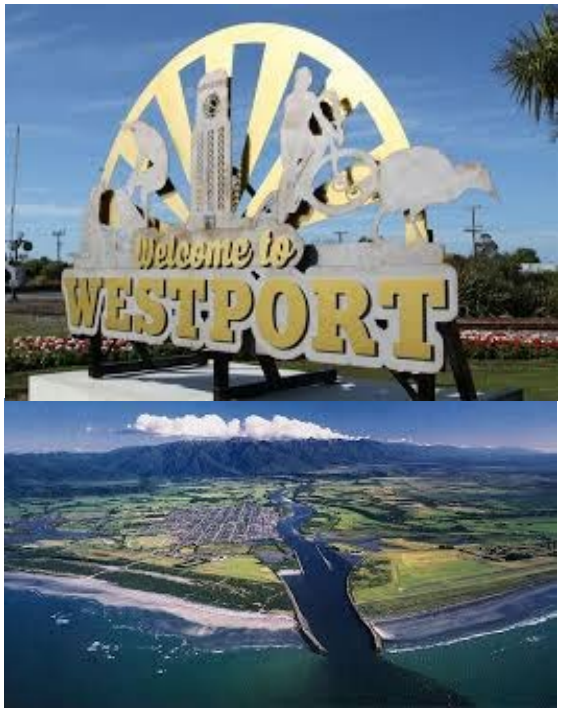
Health Quality & Safety Commission New Zealand
Kapu Tauraki Hauora o Aotearoa
KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

A little bit about me…

- Pauline Ansley



Proof that the sun shines on the West Coast and Westport is paradise (NZs best kept secret)

- Clinical Manager WCPHO
- Registered Nurse
- Rural General Practice and hospital background
- One of the smaller PHOs
- The only PHO on the West Coast

The West Coast PHO…

West Coast Te Tai o Poutini Primary Health Organisation

- 7 Practices (plus 8 rural clinics)
- 6 VLCA, 1 non VLCA
- 4 are WCDHB owned
- ≈ 30,000 patients
- Covering 513 Kms

- Coast Medical 1231
- Buller Medical (Karamea and Ngakawau rural clinics) 6219
- Reefton Medical 1532
- Greymouth Medical (Moana rural clinic) 9204
- High Street Medical 4578
- Westland Medical 5552
- South Westland Area Practices (Hari Hari, Whataroa, Franz Josef, Fox Glacier, Haast clinics) 1439

The West Coast PHO…

West Coast DHB Population

33,190 (2016/17)

- Tends to be older
- Lower proportion of Māori, almost no Pacific
- Proportionally more deprivation than nationally
- Poverty, poor literacy, unemployment, isolation and difficulties accessing health care
- Significant travel distances to main centres
- High level of disease burden
- Transient healthcare workforce

Project Overview

- **Improving the health care experience of those in our community who have been identified as having (Pre-diabetes) and Diabetes**

Improvement Team

- 2x General Practices (~ 6,300 / 4500 patients (n=10,800)

- Project teams:
  - 2 Enrolled Nurses
  - 2 Kaupapa Maori Nurses
  - 2 Kaiawhinas
  - 2 PHO Health Navigators
  - 3 RNs (2 Practice Nurse, 1 Diabetes Nurse Specialist)
  - 2 Consumers
  - 1 GP

Problem Statement

- **Review of WC Diabetes care against the National Standards identified areas for improvement, supported by:**
    - Lower than target DAR rates (77%)
    - Inequitable engagement (82% Maori, 65% Indian/Asian)
    - Significant number of people with poor diabetes control (HbA1c >64)
    - No structured programme for pre-diabetics

Impact

- Large numbers of diabetics not being reviewed and having minimal contact unless having emergencies / complications
- Suboptimal clinical care – 47% elevated HbA1c, 67% raised cholesterol – 58% on statins, 60% elevated bp, 45% elevated urine creatinine – 63% appropriately medicated
- ≈1200 pre-diabetics
- Not able to prevent progression from pre-diabetes to diabetes

Aim Statement

To reduce the average hbA1c level of Buller Medical diabetes patients with hbA1c above 64mmol/l by 10% from 82.7% to 74.4% by April 2019

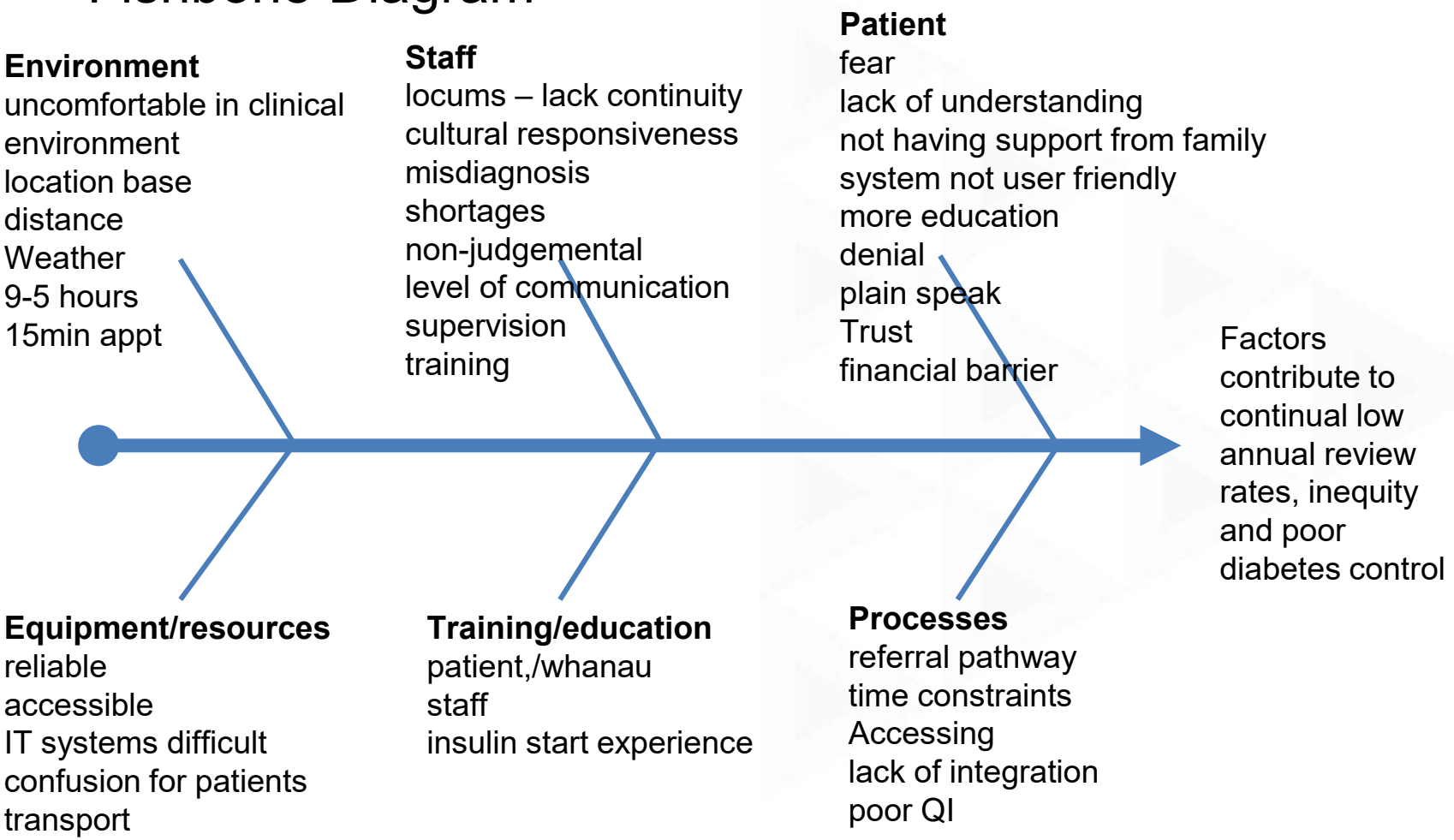
Diagnose the problem - Data

- Quantitative data
  - Karo reports: register, demographics, ethnicity, hbA1c, cholesterol, bp, renal, medications. retinal screening, DAR, CVRA,
  - Query Build: NHI level

- Qualitative data
  - Stakeholder workshop – Ishikawa Diagram
  - Process mapping Local Diabetes Team (LDT) workshop
  - LDT review of Diabetes National standards
  - Consumer voice

Diagnose the problem- Ishikawa Diagram

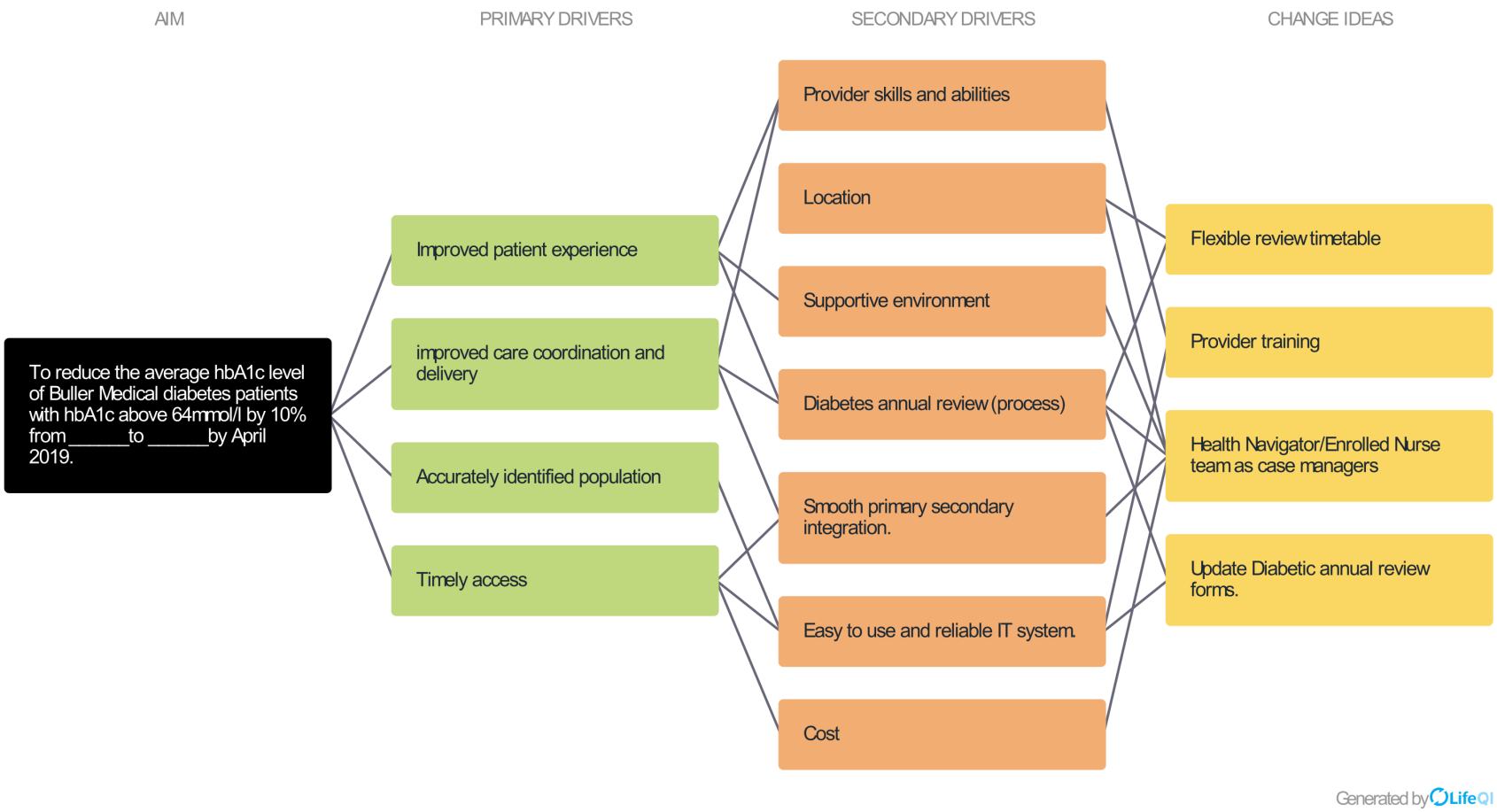
- Fishbone Diagram



Diagnose the problem- Affinity Diagram

- Improved care coordination and delivery
  - Wrap around services
  - Quality of appointment
- Timely access
- Improved patient experience and relationship
- Accurately identified population

Driver Diagram



Diagnose the problem

- Diabetes review and retinal screening have a 10-20% gap from 93-95% retinal screening and only 75-85% of DARs being completed

- Question: what motivates/enables people to access retinal screening that could be applied to Diabetes care?

Baseline Measurement

- 109 people with a latest hbA1c reading > 64mmol/l (in the last year)
  - Of which the average hbA1c is 82.7mmol/l
  - Of which 15 Maori and 1 Pacifika have an average hbA1c of 93mmol/l

Baseline Measurement

Diabetes over 16 with HBa1C over 65 in the last year to 20 Apr 2018

Number of people

QB

Karo (from DAR advanced form)

110 /Apr - Apr 2018

66 with HbA1c above 64

226 annual reviews Apr 17-Mar 18

	Type 1	Type 2	Other Diabetes	Total Diabetes	As % Total Annual Reviews	Smokers	% Smokers
NZEuro	18	163	12	193	85%	30	13%
Maori	2	12	4	18	8%	8	4%
Pacific	0	0	0	0	0%	0	0%
Indian	0	4	0	4	2%	0	0%
Other	0	11	0	11	5%	1	0%
Total	**20**	**190**	**16**	**226**	**100%**	**39**	**17%**

Baseline Measurement

			TC >=4	% TC >= 4	> =4 & on Statins	% >=4 on Statins	Systolic >130	Diastolic >80	% Sys greater than 130	% Dias greater than 80
		NZEuro	128	87%	75	59%	104	33	54%	17%
		Maori	12	8%	5	42%	9	6	50%	33%
		Pacific	0	0%	0	0	0	0	0	0
		Indian	3	2%	3	100%	0	0	0	0
		Other	4	1%	1	25%	5	4	45%	36%
		Total	**147**	**65%**	**84**	**57%**	**118**	**43**	**52%**	**19%**
PMS/Q B			**HbA1c >64**	**% HbA1c >64**	**Urine Creat ratio >4**	**% Greater than 4**	**> 4 & on Ace Inh**	**% > 4 on Ace**	**Retinal Exam in Past 2yrs**	**% Annual Reviews receiving Ret Exams**
89		NZEuro	52	23%	56	25%	36	64%	179	79%
14		Maori	8	4%	4	2%	4	100%	17	8%
1		Pacific	0	0%	0	0%	0	0%	0	0%
1		Indian	1	0%	0	0%	0	0%	4	2%
5		Other	4	2%	1	0%	1	100%	9	4%
110		**Total**	**65**	**29%**	**61**	**27%**	**41**	**67%**	**209**	**92%**

Project Measurements

Measure Name:	**Operational Definition:**	**Data Source(s)**	**Data Collection:** Schedule Method	**Baseline:** Period Value	**Goals:** Short Term Long Term
Outcome measures					
					Short term goal: *Long term goal:*
Process Measures					
					Short term goal: *Long term goal:*
Balancing Measures					
					Short term goal: *Long term goal:*

Capturing the Patient Experience

- Whakakotahi regional meeting - consumers present - 2 local diabetic patients one who is chair of local consumer working group
- 2 consumers on LDT
- 2 consumers on project teams

Voice of the Customer

- Keen to be involved
- Enjoyable

- Access problems
  - Transport
  - Time and communication
  - Availability of services
  - Family/whanau involvement for support
  - Respect
  - Cultural awareness and competency

Stakeholder / Consumer co-design

- Stakeholder analysis and communication plan
  - Stakeholders invited to HQSC site visits/workshops
  - Regular meetings with support team for project team
  - Patient survey for DAR consumers - PDSA
  - Participate in any relevant training
  - Communication
  - Teamwork - using key provider groups – e.g. Poutini Waiora, health navigators
  - Transalpine diabetes support
  - LDT support
  - Consumer co-design