Tāmaki Health

Supporting White Cross Local Doctors

COUNTIES MANUKAU HEALTH

A consumer centred approach to improving patients' diabetes control.

Whakakotahi project

2019

Date:

Created by:

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Background

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- There are 37,000 people with diabetes in Counties Manukau DHB
- Of those, more than 8,500 have been identified as poorly controlled with an HbA1c > 74.9 mmol/mol.
- poor control is associated with the later development of disabling and life threatening complications.
- Complications include increased cardiovascular risk such as heart attacks and strokes, kidney damage, visual loss and loss of feeling to legs that can lead to amputations.

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Background

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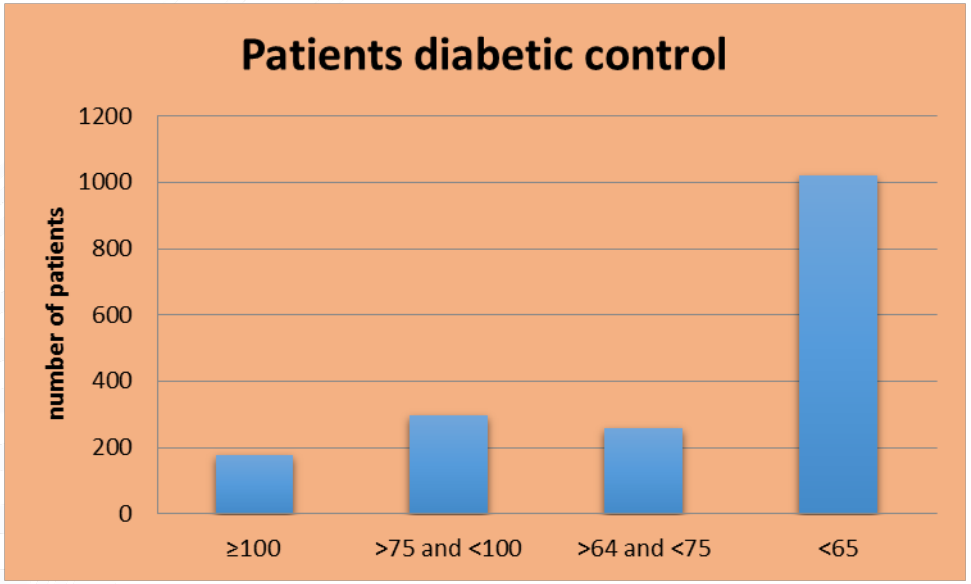
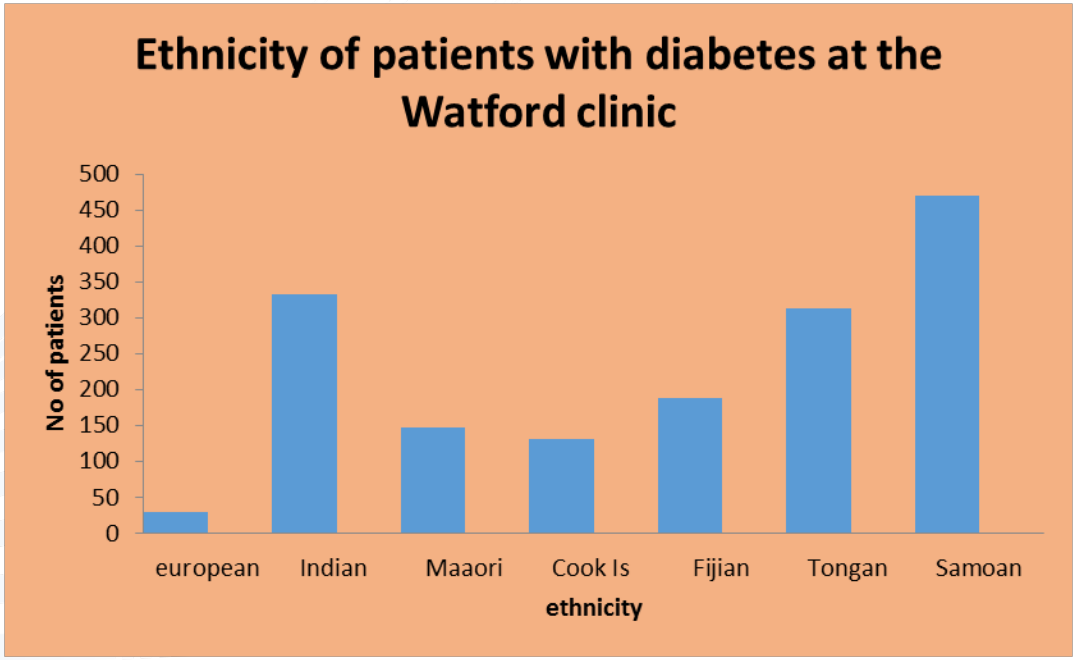
- At Watford clinic there are 1,746 patients with diabetes.
- 42% of these patients are not well controlled



Background

- The majority of the patients with diabetes are Pacific Islanders with Samoan people being the largest ethnic group



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The Practice

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In April 2019 Bairds road surgery moved across the road to it's new premises and was renamed Watford Clinic

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Our Team

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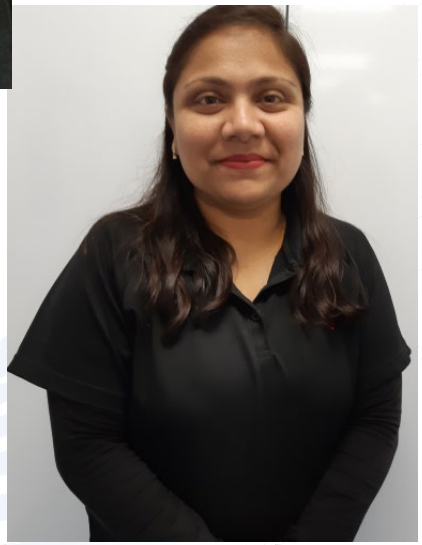
Sue Tutty
Project lead

Care Coordinator
Anjini Ram Kumar

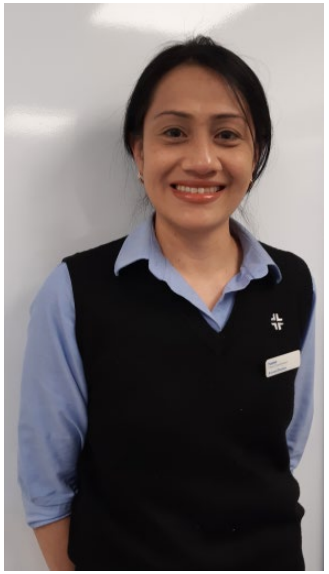
Bhupinder Kaur
Diabetes nurse

<u>Absent</u>
Diabetes nurse specialists: Harpreet Kaur/ Kate Smallman
Clinical Family Navigator: Priya Francis
Sponsor: Andrew Warner



Sheetal Patel
Health Coach

Rachna Kumari
Receptionist



Ivona Savali
Centre Manager

Problem Statement

- Diabetes is a cause of significant morbidity and mortality in South Auckland
- Watford clinic is a busy clinic covering both family medicine and acute care and sees a large number of diabetic patients
- Many of our diabetic patients do not engage well in their diabetes care.
- By empowering patients more in their diabetes care we can improve patients outcomes.

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Inequity

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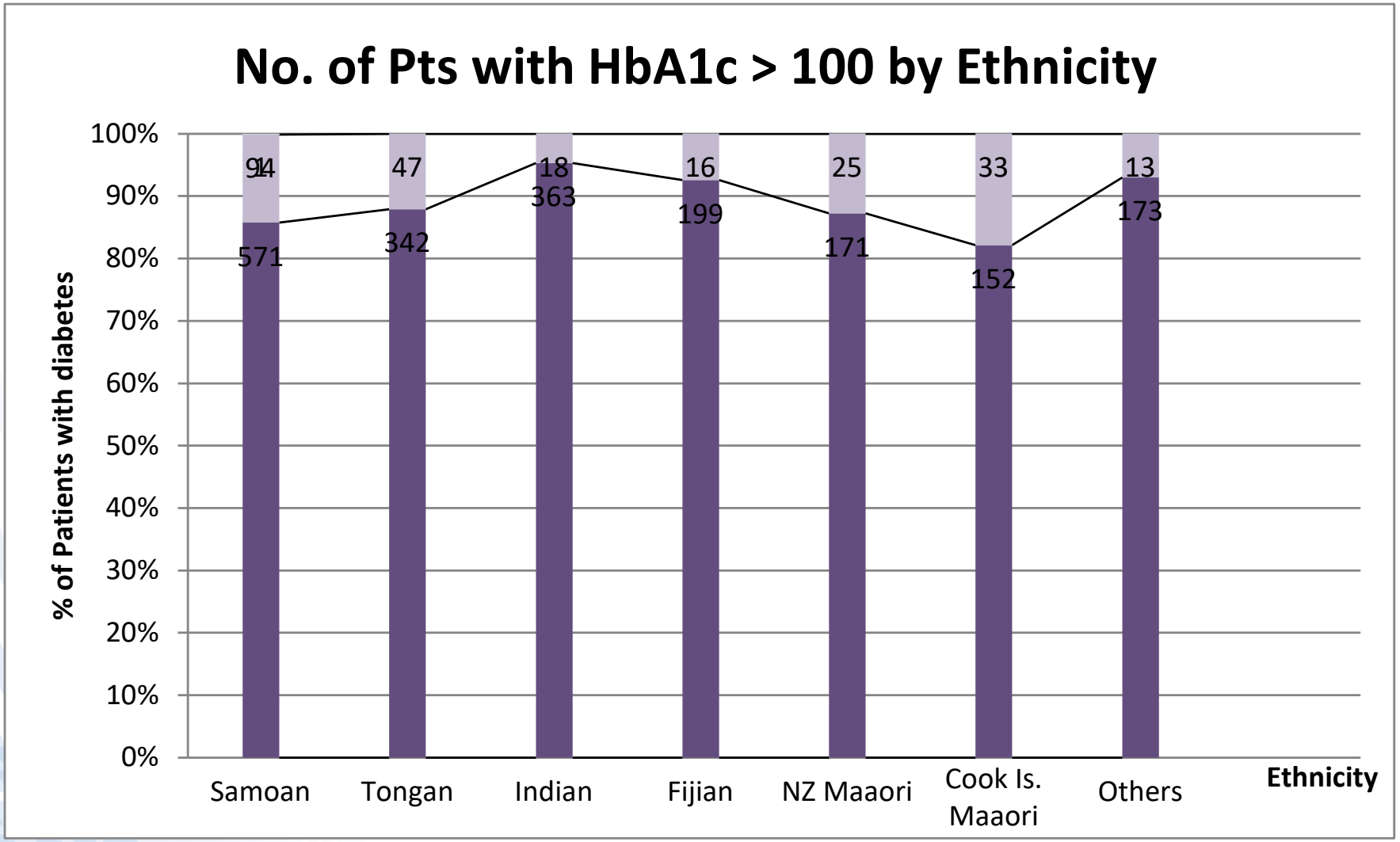


Aim Statement

To reduce the number of patients

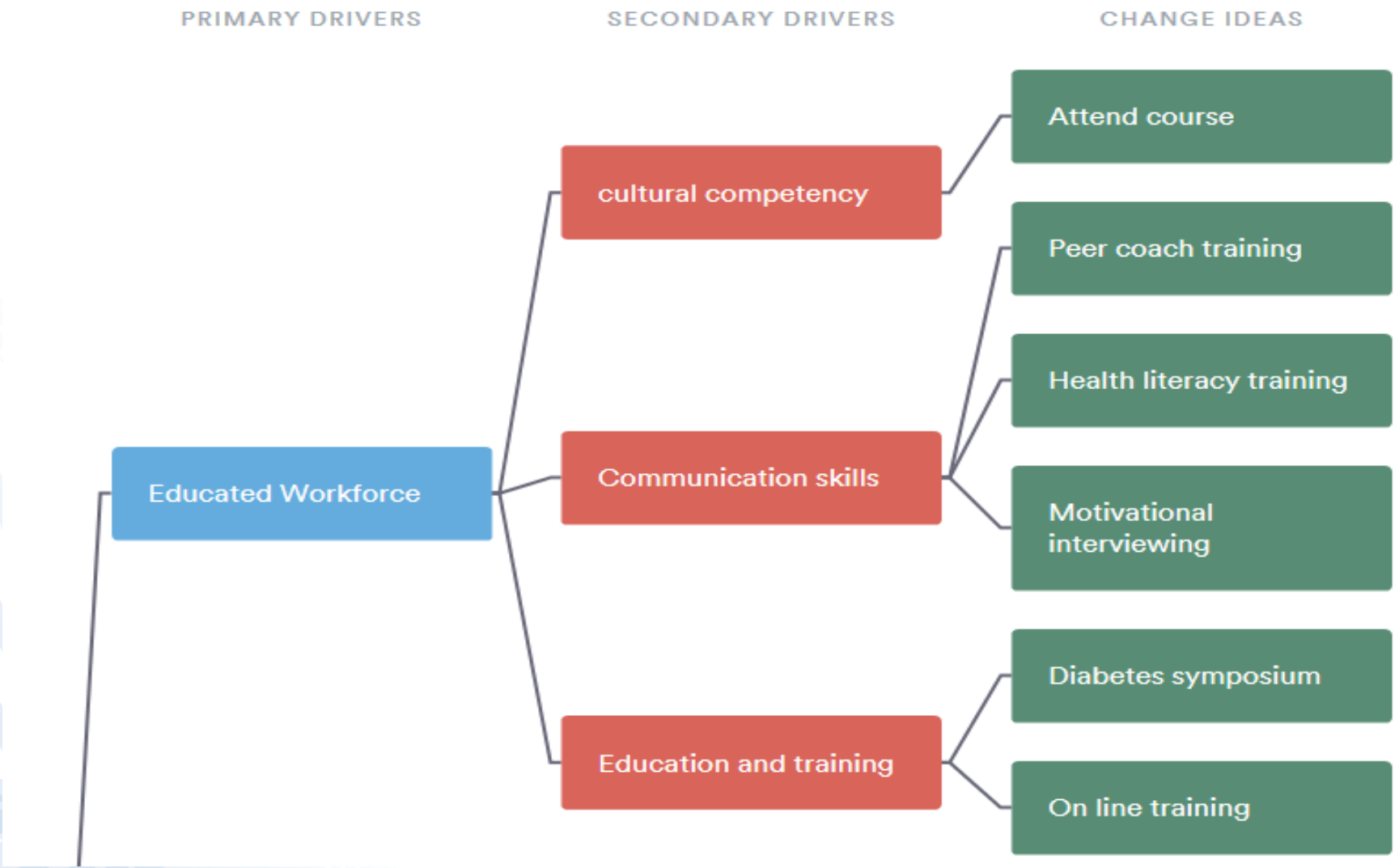
enrolled at Watford Clinic

with a Hba1c >100

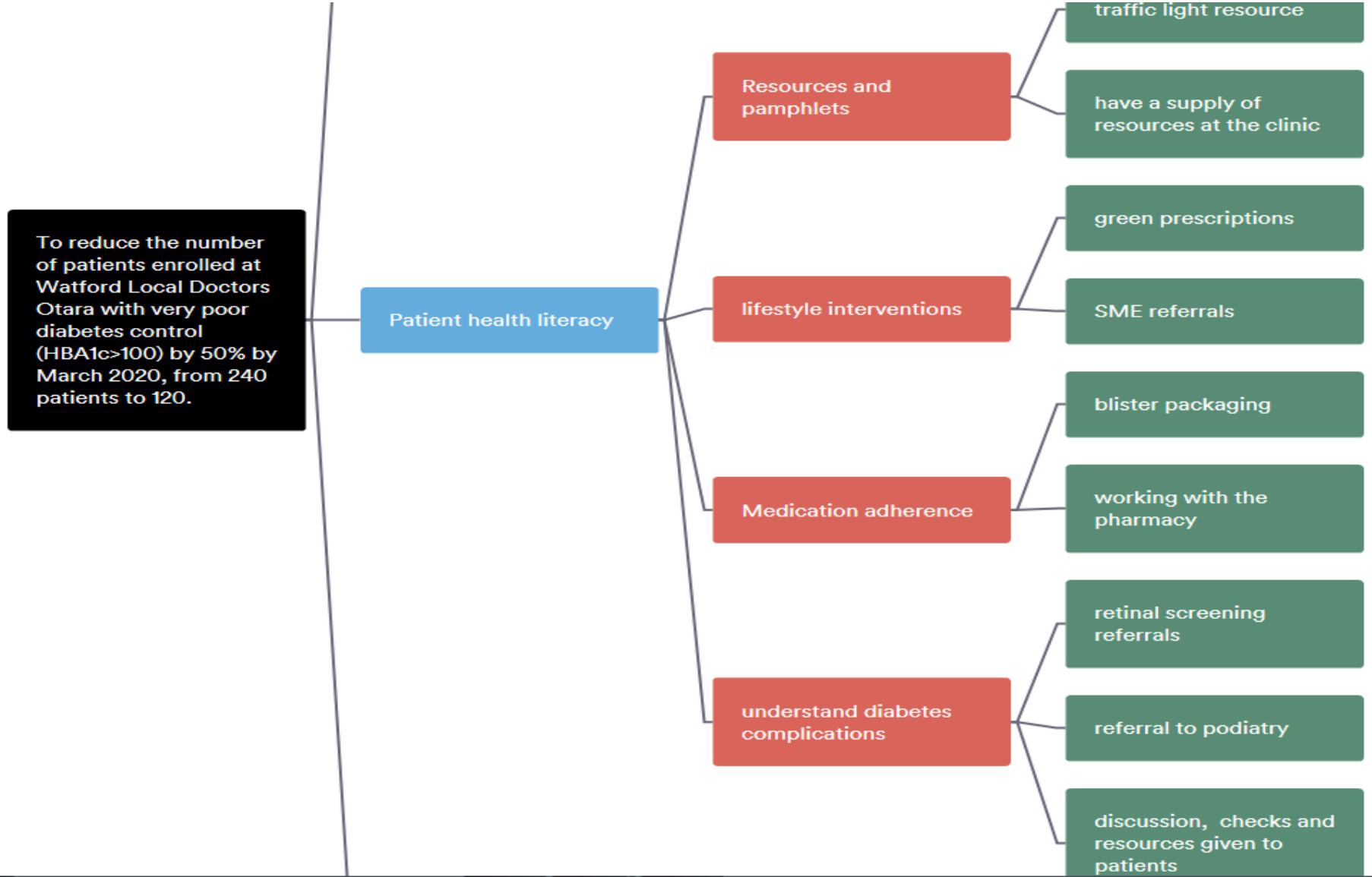
by 50% (from 240 patients to 120 patients)

by March 2020.

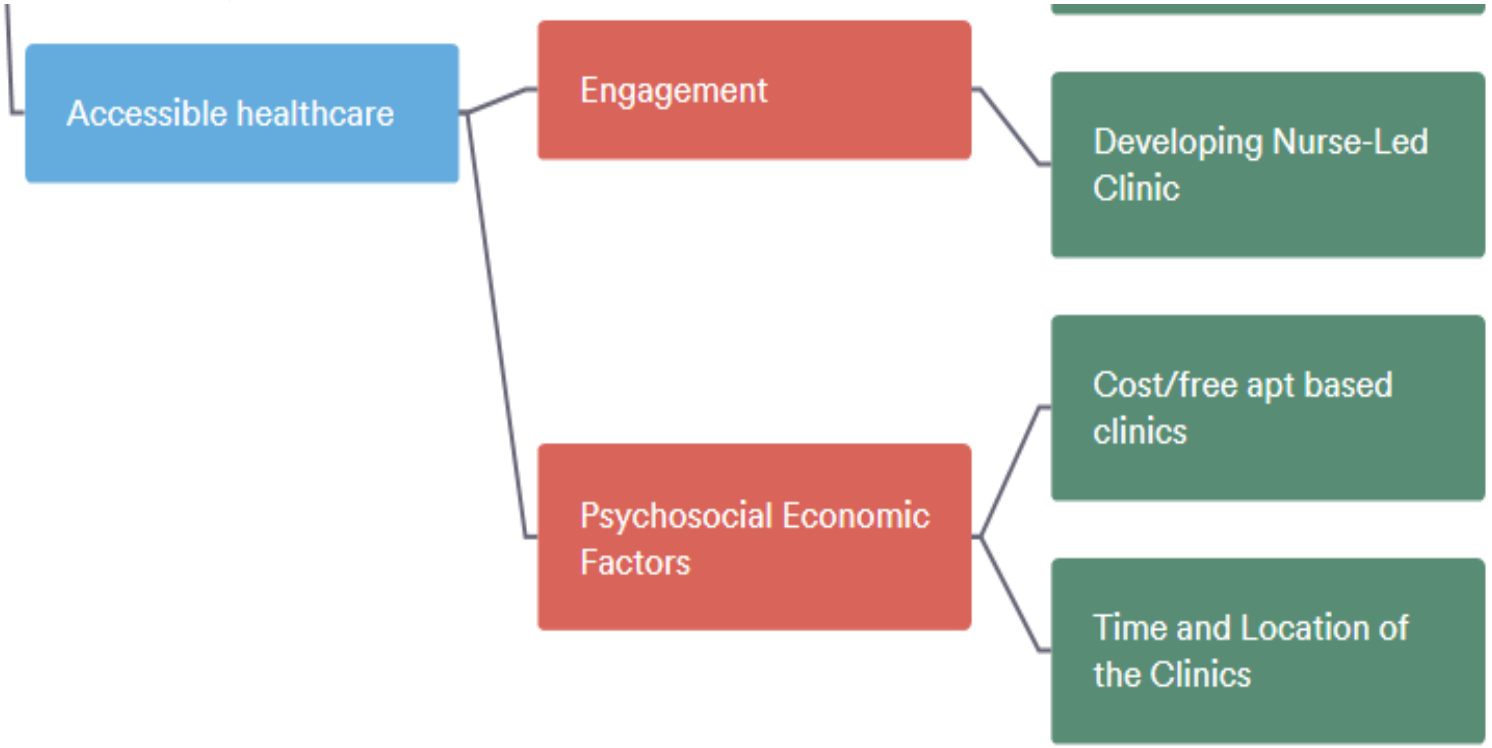
Driver diagram



Driver diagram



Driver diagram



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Goals of Care

Management of Hyperglycemia in Type 2 Diabetes, 2018.A Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD)
https://doi.org/10.2337/dci18-0033

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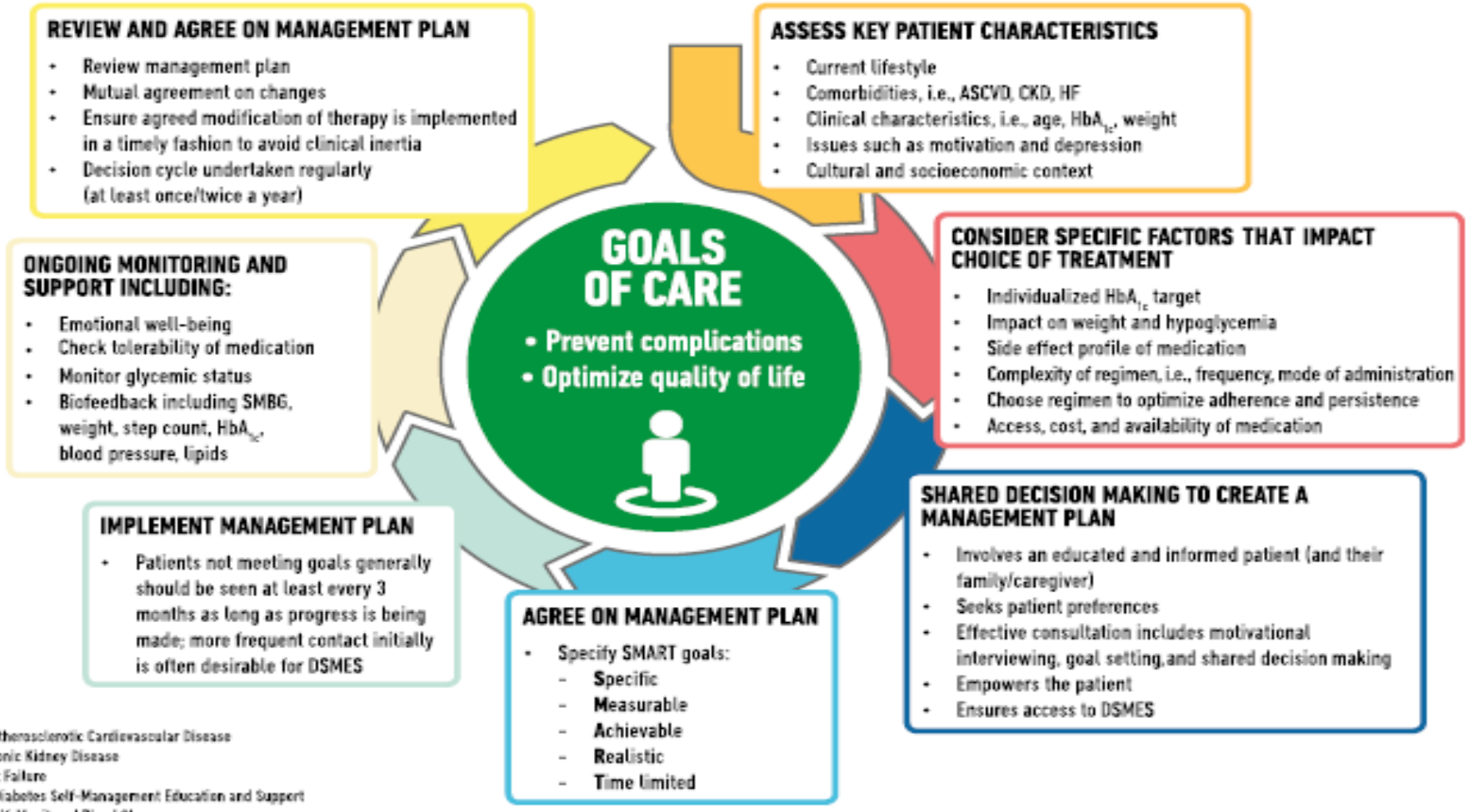
DECISION CYCLE FOR PATIENT-CENTERED GLYCEMIC MANAGEMENT IN TYPE 2 DIABETES



ASCVD = Atherosclerotic Cardiovascular Disease
CKD = Chronic Kidney Disease
HF = Heart Failure
DSMES = Diabetes Self-Management Education and Support
SMBG = Self-Monitored Blood Glucose

Figure 1—Decision cycle for patient-centered glycemic management in type 2 diabetes.

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Initial Outcome Data

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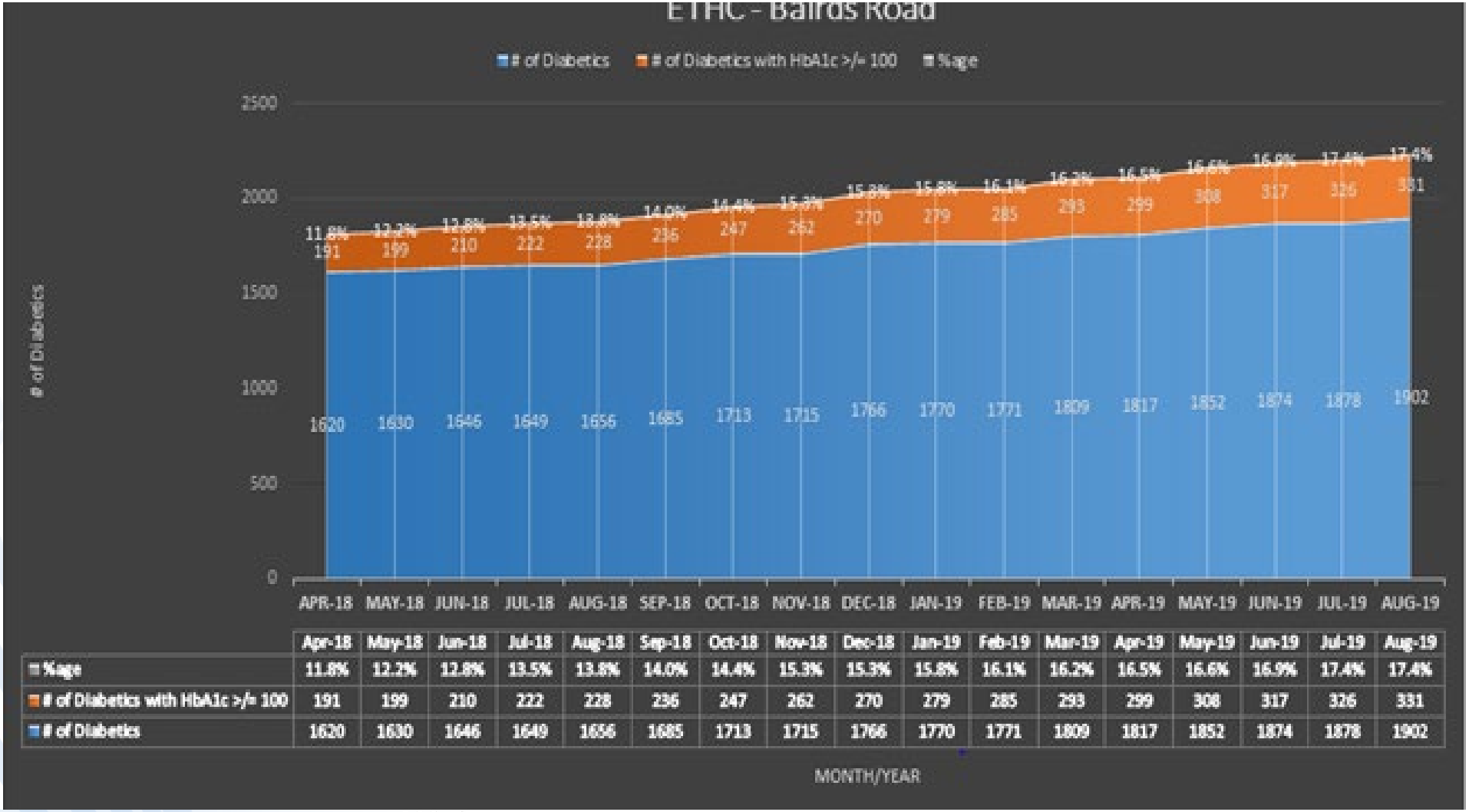

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
%age	11.8%	12.2%	12.8%	13.5%	13.8%	14.0%	14.4%	15.3%	15.3%	15.8%	16.1%	16.2%	16.5%	16.6%	16.9%	17.4%	17.4%
# of Diabetics with HbA1c >/= 100	191	199	210	222	228	236	247	262	270	279	285	293	299	308	317	326	331
# of Diabetics	1620	1630	1646	1649	1656	1685	1713	1715	1766	1770	1771	1809	1817	1852	1874	1878	1902

Diagnose the Problem

- The number of patients with diabetes at Watford clinic is increasing
- The number of patients with HbA1c over 100 is increasing more than the number of diabetics
- At present this project has not impacted on the problem

Diagnose the problem

- Codesign
- Attempting to engage the patients
- Recording all encounters - Data sheets

<u>So far:</u>

Called 89 patients

Excluded 8 patients being seen by DNS or 2° care

39 priority patients seen

30 “other” patients seen

Capturing the patient experience

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The challenges for our patients

"I don't check my blood sugar as it is always high"

"Don't cut the fat of the food. It is wasting food"

"Working 12-20 hours a day"

"Do I need to take all these tablets?"

Voice of the Customer

- I have been really naughty. If I don't look after myself I can't look after my husband
- I am happy to have 2 angels looking after me
- Had a long chat-feeling much more confident about my diabetes now
- I knew everything previously but was not confident and not too sure
- I had that block head thing- like "It'll be alright." Now I know I need to take my meds.
- I've not been taking my medications regularly- I didn't think it mattered too much

Dashboard of Measures

Outcome Measure

A reduction in the number of patients at the Watford clinic with a HbA1c >100

Process Measures

- Attendance at the clinic –turning up and coming back
- Referrals and attendance at SME
- Referrals and attendance at Wellness support
- Referrals and attendance to Retinal screening

Balancing Measures

More patients with diabetes in the poorly controlled range HA1c >65

Change ideas to test

Educated workforce

- Attendance at education sessions
- Discussions at team meetings
- Working with health coaches
- Cultural competency – learning from our patients in codesign

Change ideas to test

Patient health literacy

1. Use of resources

- Traffic light resource
- Other pamphlets
- Resources for testing blood glucose

2. Referral to additional supports

- Green prescriptions
- SME
- Wellness team

3. Understanding complications of diabetes

- Podiatry
- Retinal screening
- Secondary care appointments

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Change ideas to test

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Change ideas to test

Accessible Heathcare

1. Timing of the clinic

- A morning clinic vs an afternoon clinic
- An evening clinic
- A weekend clinic
- Ethnicity differences in attendance
- appointments

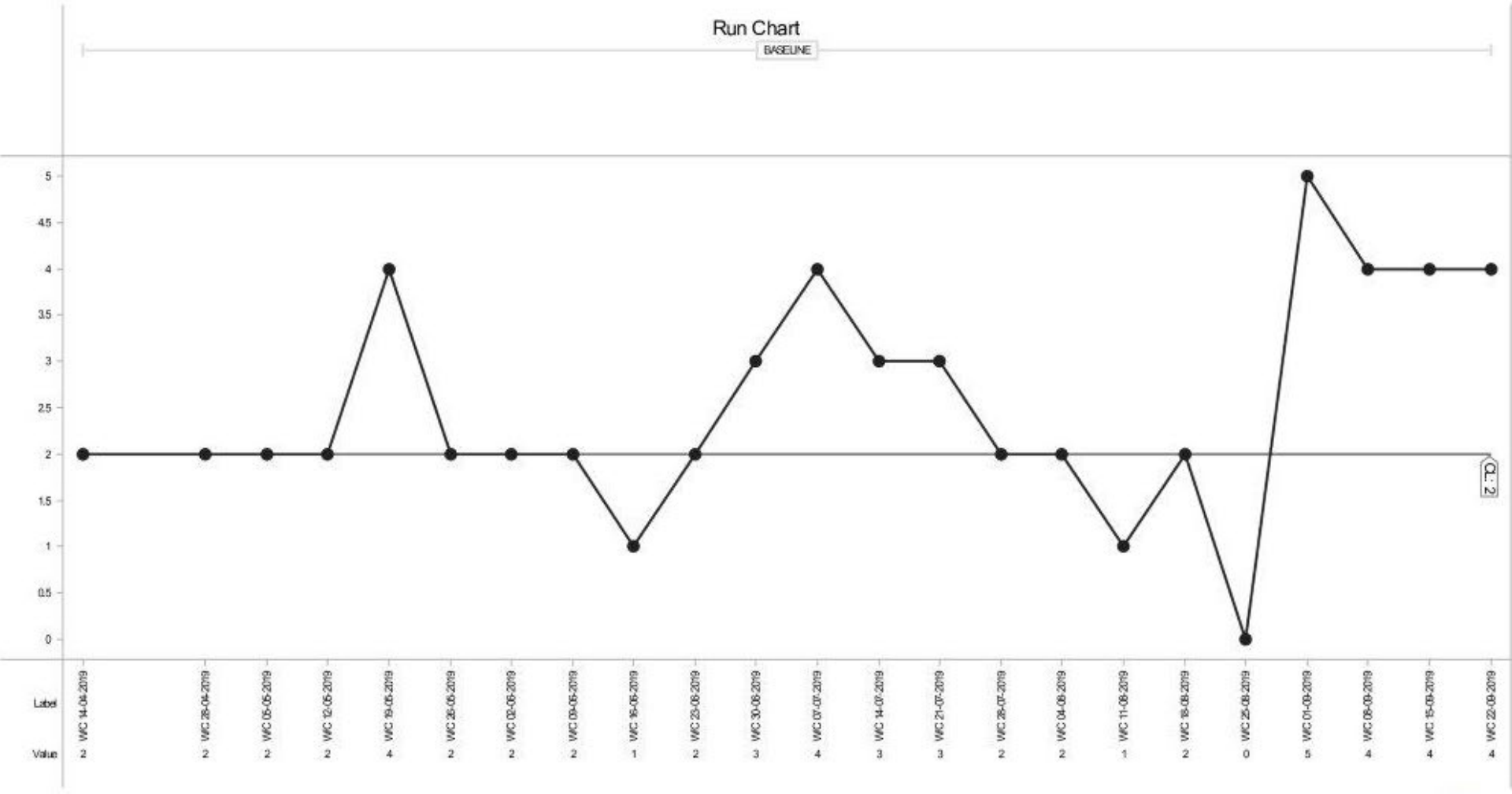
2. Appointment based clinic

- Administrative support for making bookings
- Soft phone calls with a health coach script

3. Nurse led clinic

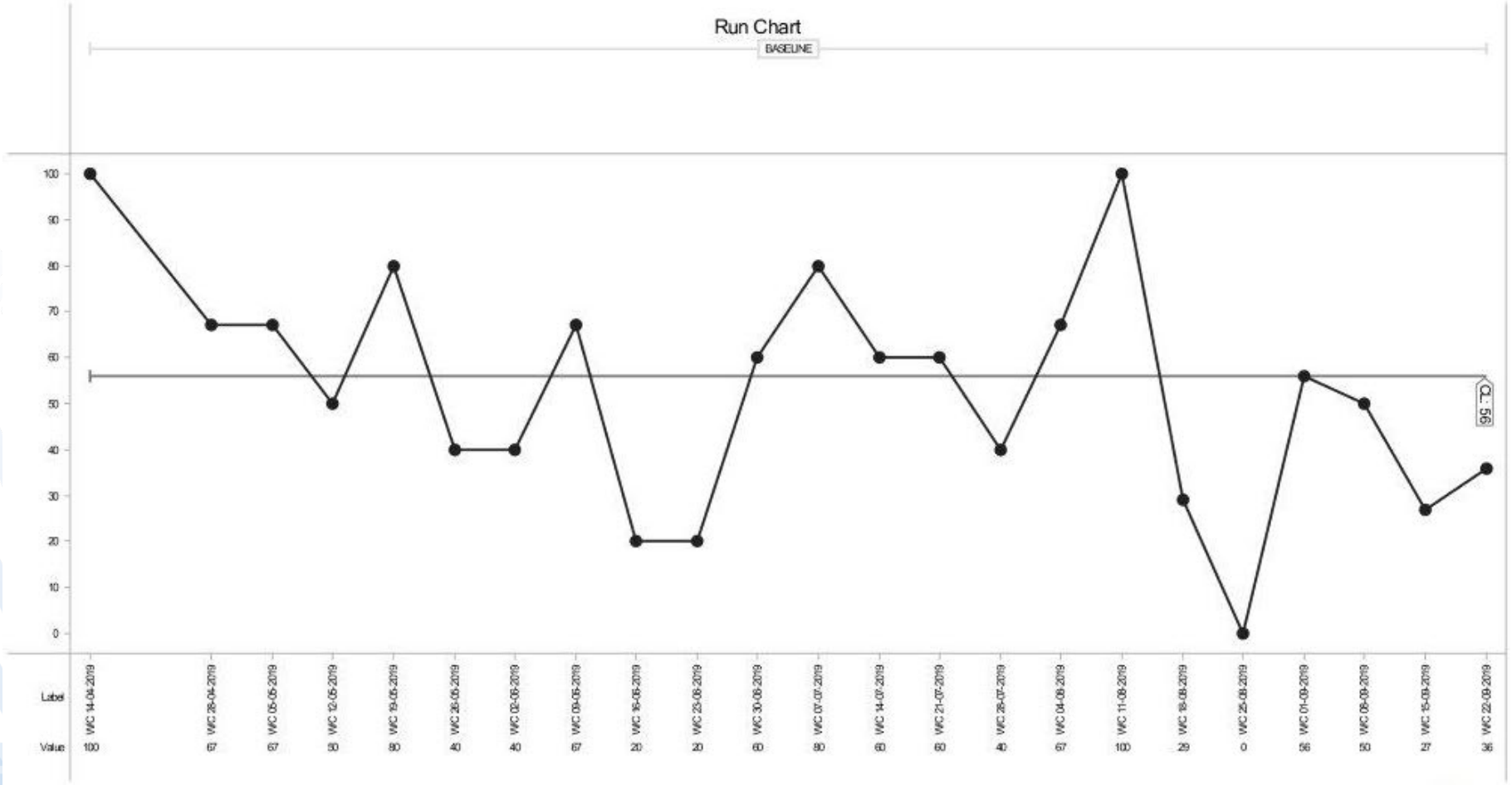
What are we currently testing

Attendance at the clinic



Data- run charts

Attendance at diabetes clinic as a % of appointments



Highlights

The enthusiasm of the patients to make a change when they understand more about their diabetes

The opportunity to make a difference in the lives of our patients and their whanau

Working together as a team

Having the support of management

Lowlights

When others don't see the need for our patients and our community

Barriers that interrupt the work such as staff turnover, moving location, work capacity

Socioeconomic factors that are outside our control.

Key Success

This is a codesign project so the focus is always the patient - Every patient that as a result of this intervention will no longer progress to dialysis, blindness or amputation is a success. Every whanau who will not loose a loved one at an early age is a success.

By the end of the project the hope is to have developed a model of care that more closely meets the needs of our patients and that can be spread to other centres.

Key Barriers

- the vision and time constraints in the practice
- incorporating quality improvement into a surgery that is focused on acute work
- Making data inform practice
- Developing strategies to use resources in a more cost effective and efficient manner

Having lost our quality improvement trainees to inform our team we have struggled with Life QI, data recording and analysis.

The lack of support from the practice nurses

Lessons learned

There is huge need in our community

Equity is not been addressed well

Quality improvement needs a committed team and management support.