Tāmaki Health

Supporting White Cross Local Doctors

COUNTIES MANUKAU HEALTH

A consumer centred approach to improving diabetes control

Whakakotahi project

2019/20

Date:

Created by: Sue Tutty

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Our Team

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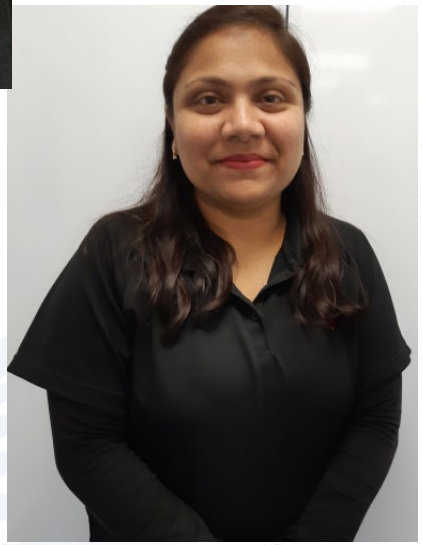
Sue Tutty
Project lead/GP

Care Coordinator
Anjini Ram Kumar

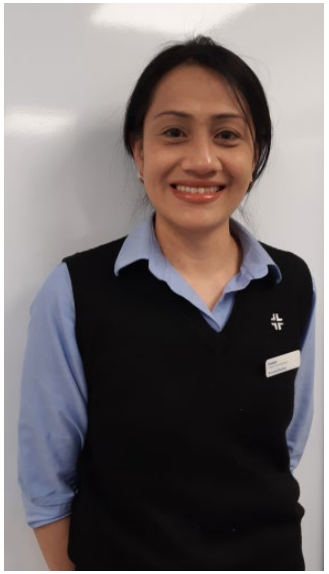
Bhupinder Kaur
Diabetes nurse

<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

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The Practice

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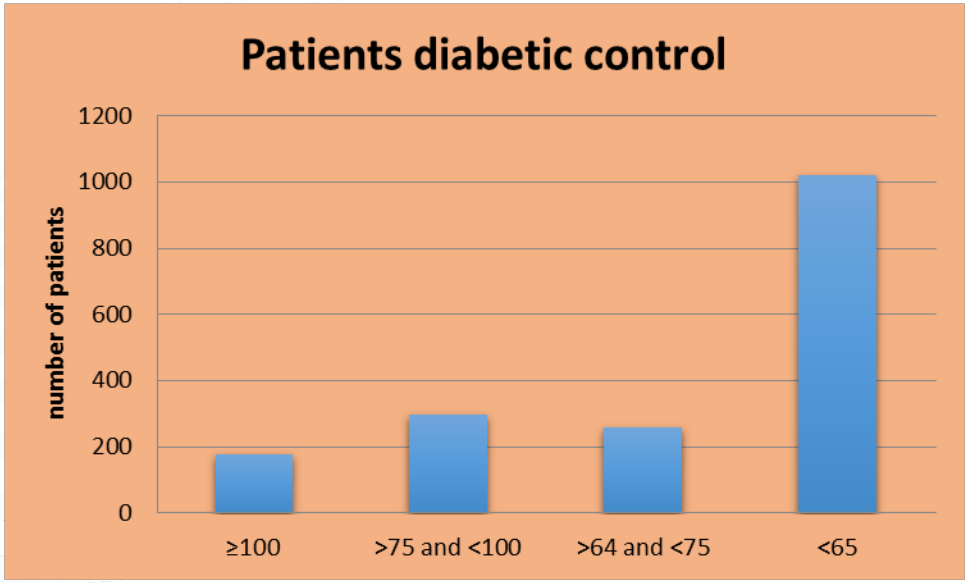
In April 2019 Bairds road surgery moved across the road to it's new premises and was renamed Local Doctors - Otara

The Problem

- 41,174 people are diagnosed with diabetes in Counties Manukau DHB region
- 8,844 have been identified as having poor control with an HbA1c≥ 75mmol/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

Diagnosing the problem

- At Local Doctors –Otara 1,746 people have been diagnosed with diabetes
- Good control is a HbA1c <65. 42% of the people with diabetes at this clinic do not have good control



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Ethnicity data

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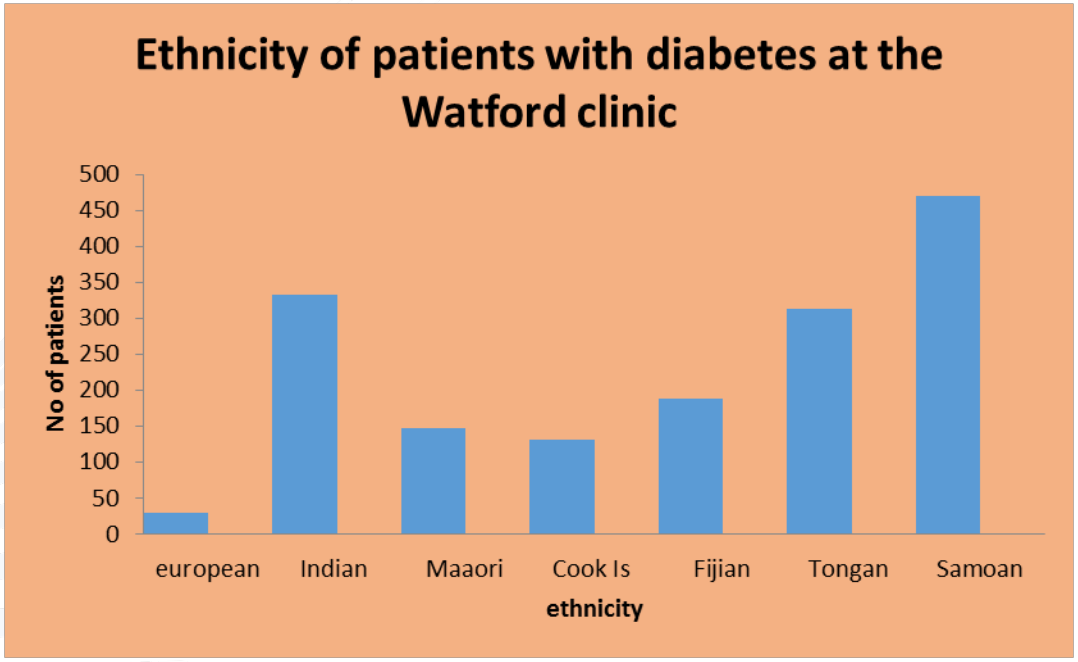
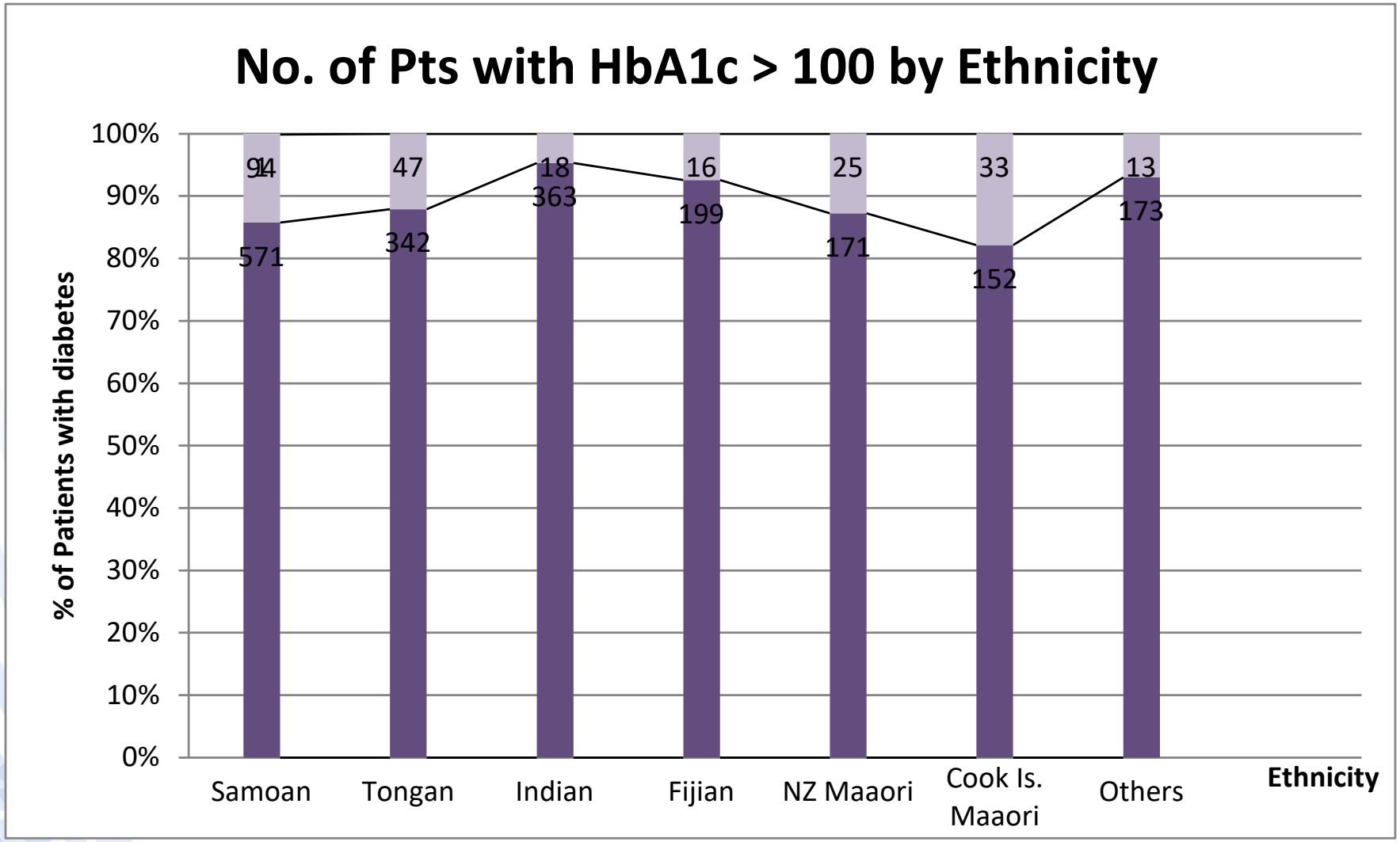
The prevalence of Diabetes in the Auckland metro region is 4.9% European, 8.6% NZ Māori, 12% Indian and 15.1% people from the Pacific Islands



Ethnicity data



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The Challenge

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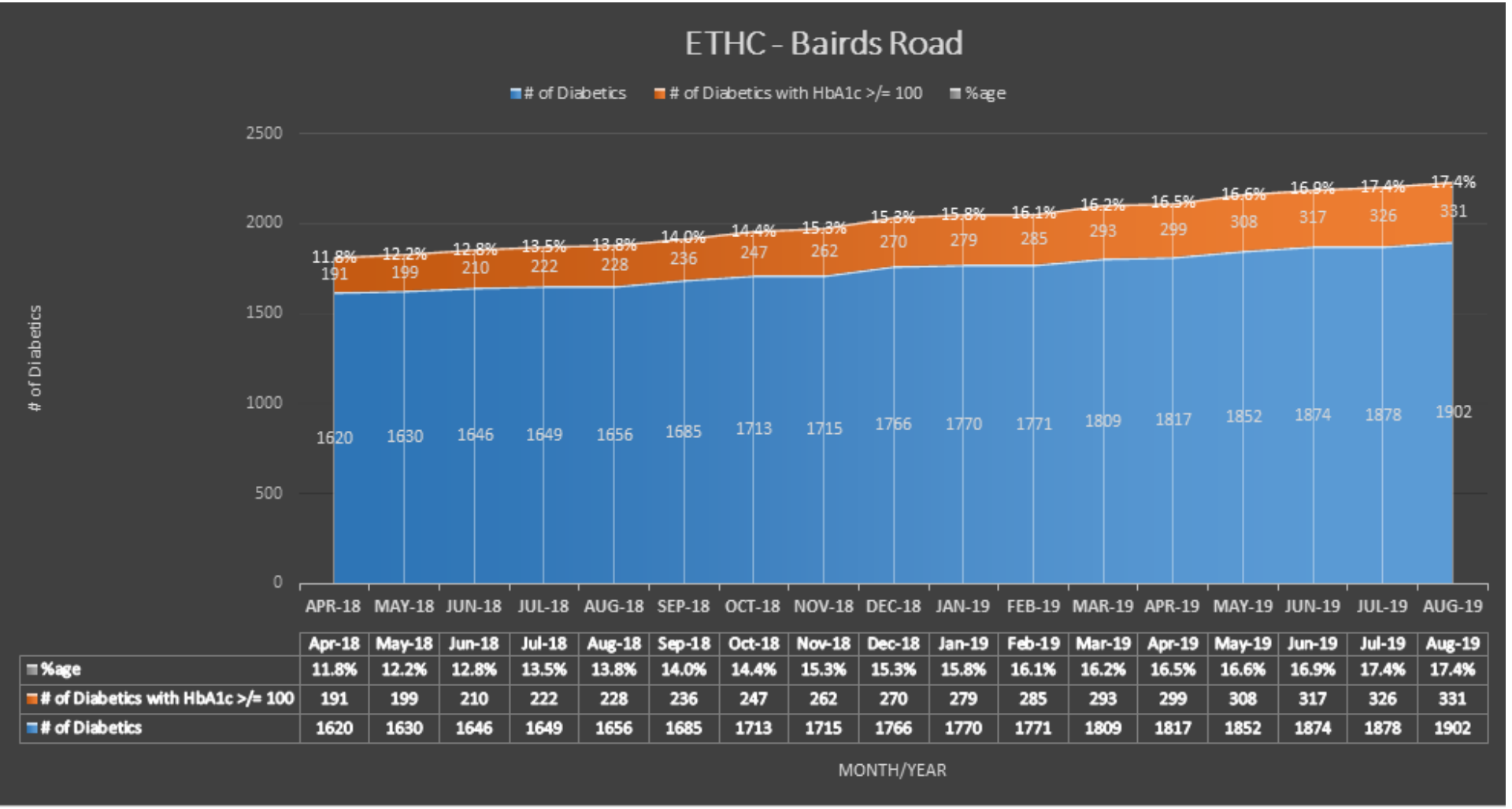

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
%age	11.8%	12.2%	12.8%	13.5%	13.8%	14.0%	14.4%	15.3%	15.3%	15.8%	16.1%	16.2%	16.5%	16.6%	16.9%	17.4%	17.4%
# of Diabetics with HbA1c >/= 100	191	199	210	222	228	236	247	262	270	279	285	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

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The Challenge

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- The number of people diagnosed with diabetes is increasing
- The number of people with an HbA1c over 100mmol/L is increasing more than the number of people being diagnosed with diabetes
- Local Doctors- Otara is a busy clinic covering both family medicine and acute care and see a large number of people diagnosed with diabetes
- Many of the people diagnosed with diabetes are not well engaged in their diabetes management

Capturing the experience

The challenges……..

“I don’t check my blood sugar as it is always high”

“Don’t cut the fat off the food. It is wasting food”

“Working 12-20 hours a day”

“Do I need to take all these tablets?”

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Aim Statement

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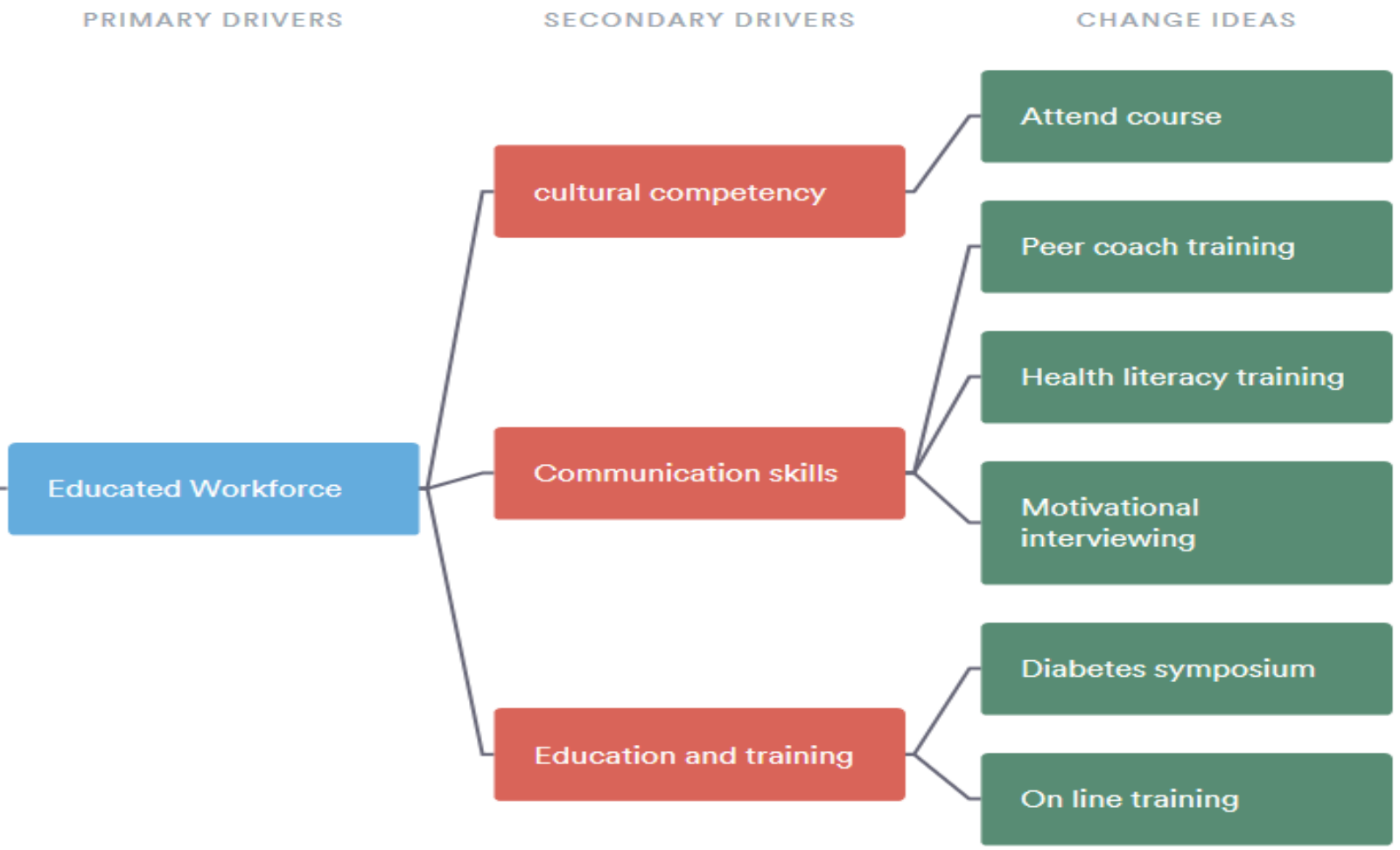
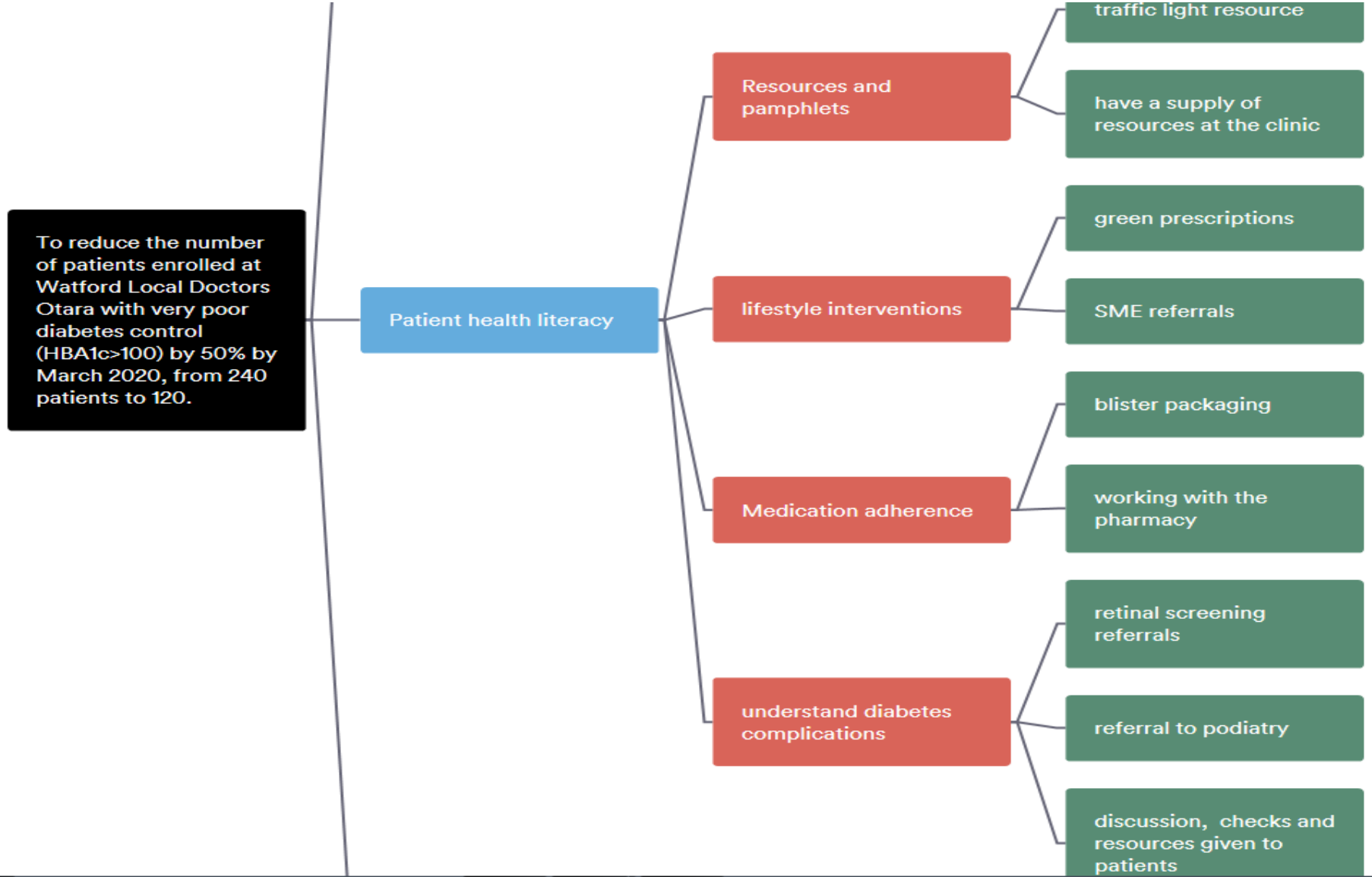
To reduce the number of patients who are enrolled at Local doctors- Otara with an Hba1c >100mmol/L by 50% (from 240 patients to 120 patients) by March 2020

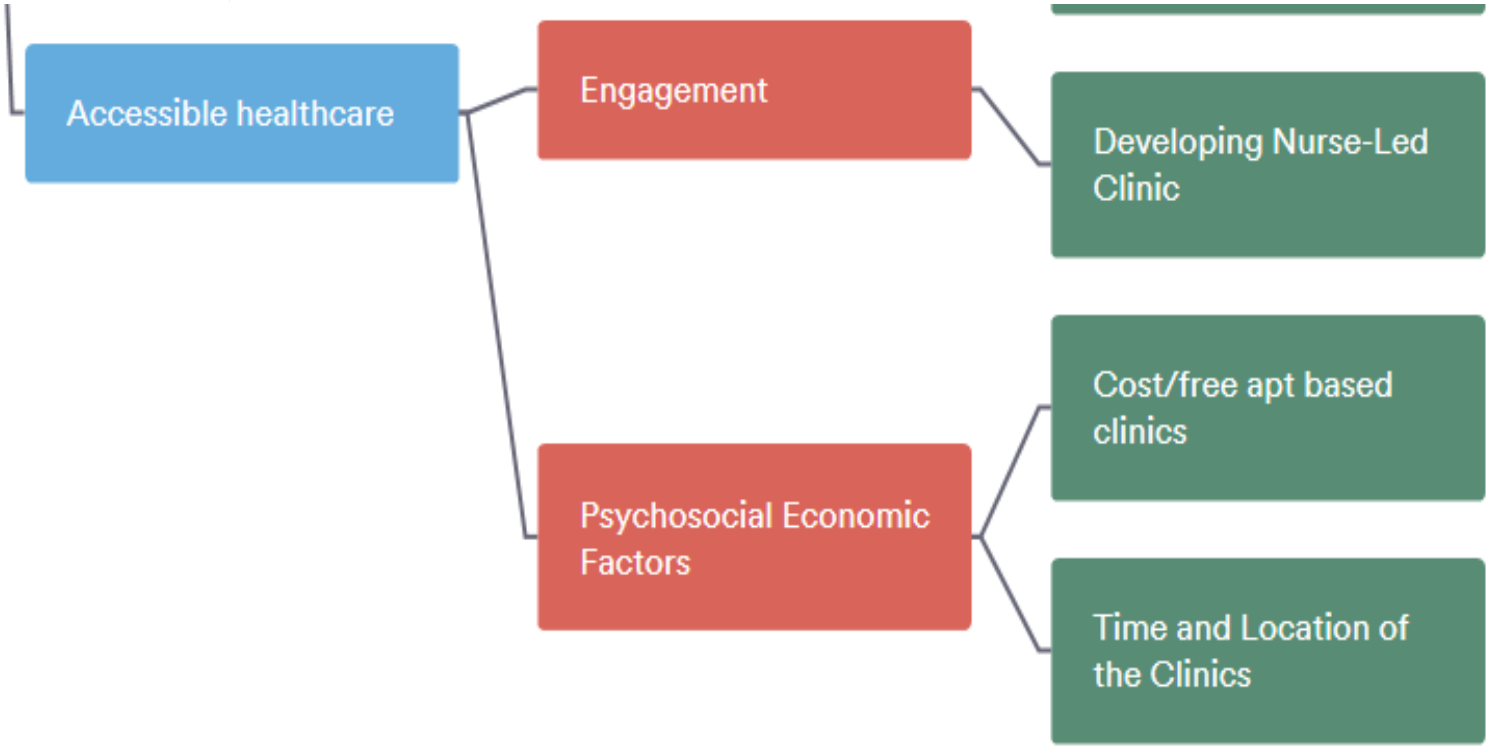
Driver diagram



Driver diagram



Driver diagram



Family of Measures

Outcome Measure

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

Process Measures

- Attendance at the clinic –turning up and coming back
- Referrals and attendance at SME
- Traffic light resource

Balancing Measures

An increase of people with diabetes in the poorly controlled range HbA1c >65mmol/L

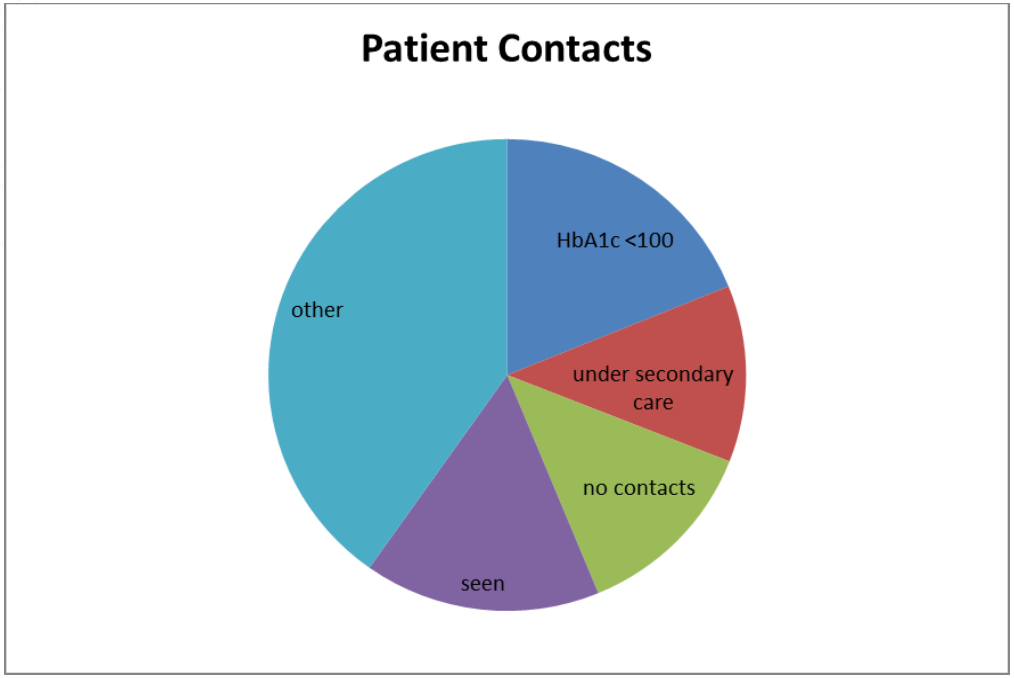
What we did

- Codesign
- Invite patients to attend the clinic
- Work with the patients
- Record all the encounters - Data sheets

Accessible healthcare

Who were we working with?

- Started with 245 pts with HbA1c>100 in last 15 months
- Excluded 53 as HbA1c now < 100 = 192
- 34 under secondary care (including DNS) = 158
- 36 had no contacts = 122
- Seen at clinic =45



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Accessible healthcare

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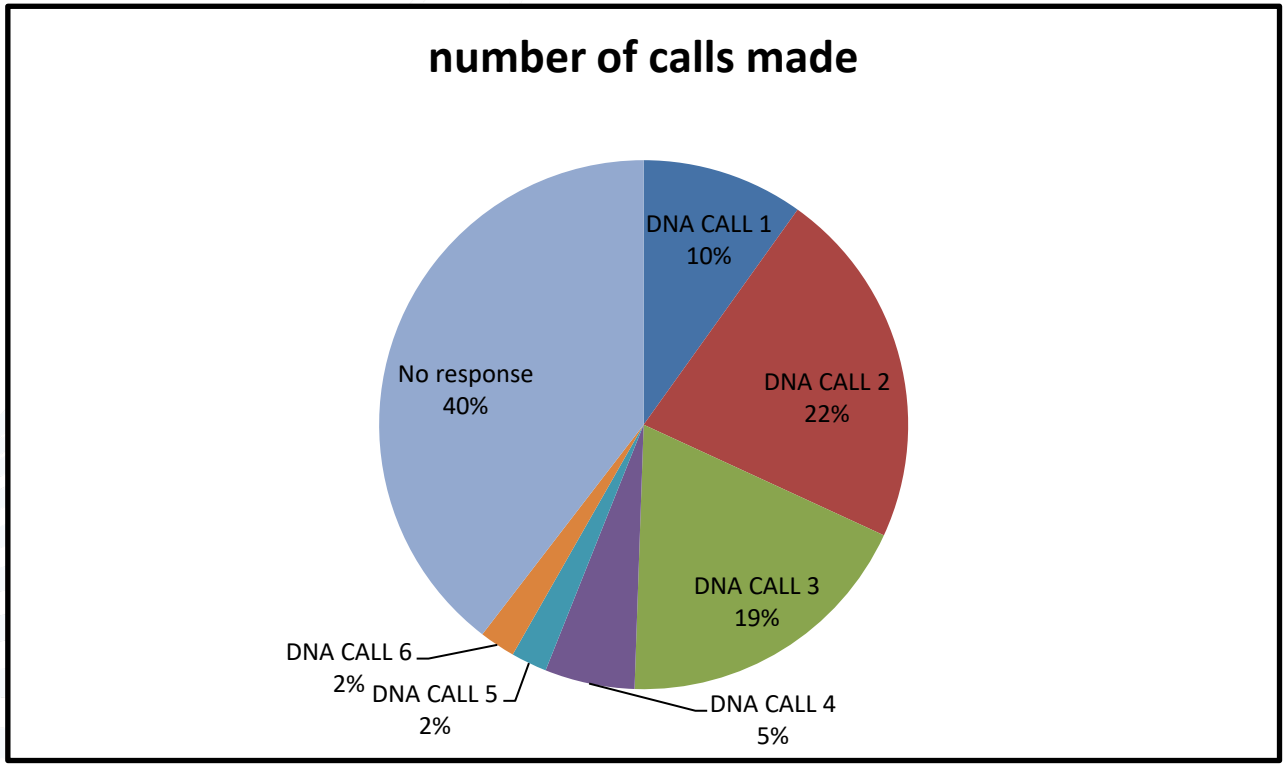
What did we need to do to get the patient to the clinic?

- 36 patients had no valid number
- 143 phone calls were made to the remaining 55 patients



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Accessible healthcare

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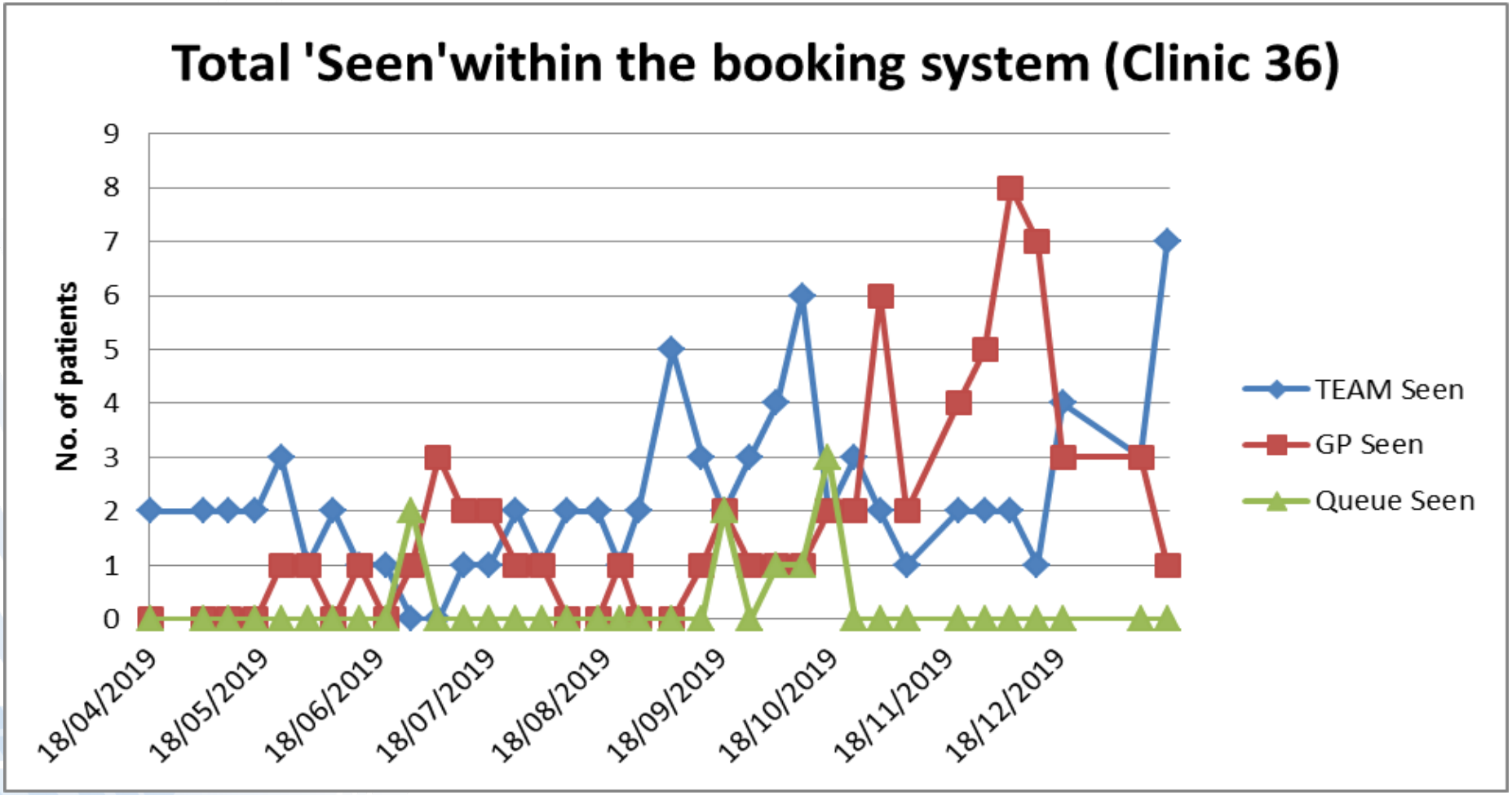
Team patients and GP patients



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Accessible healthcare

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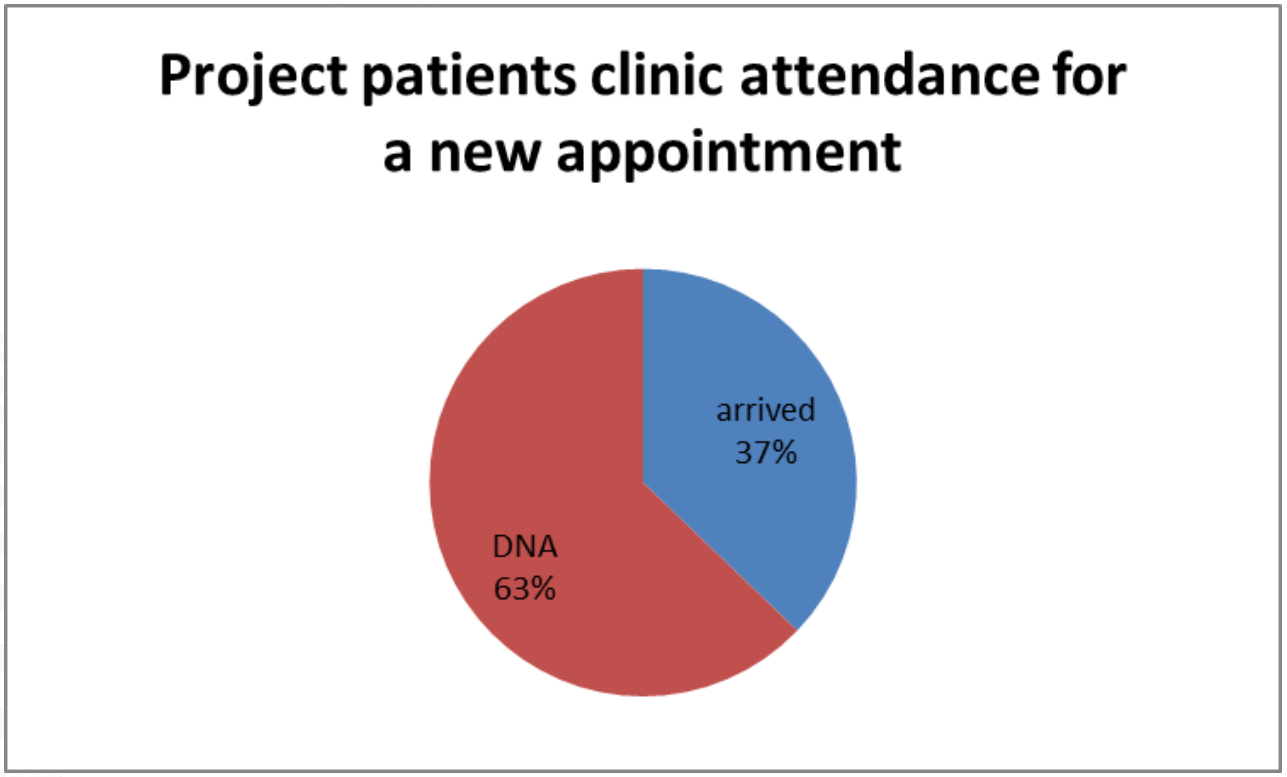
How many project patients were seen?

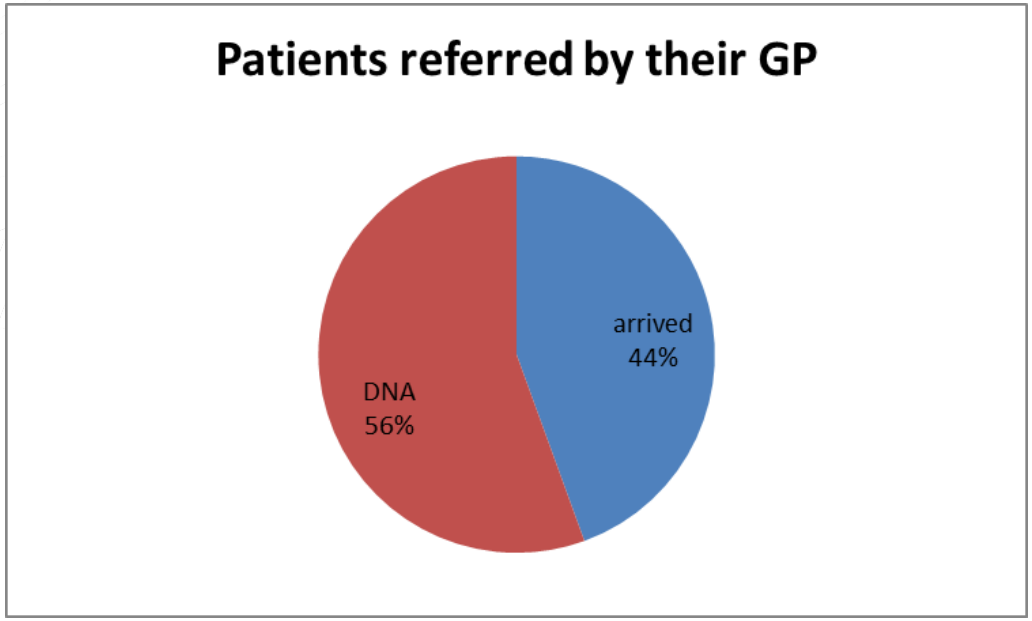
- 42 Whakakotahi patients were seen in the clinic
- 71 patients DNA's their first clinic appointment



Accessible healthcare

Would patients referred from their GP be more likely to arrive?

- Already had a contact
- Partially engaged
- 113 of the new patient appointments were patients referred from their GP
  - 52 arrived
  - 65 DNA



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Accessible Healthcare

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If they miss their first appointment should we keep trying to recall them?

- Patients who DNA their first clinic attendance are more likely to continue to DNA their second and third appointments
- They are more likely to be unable to be reached
- After 4 DNAs no-one turned up at the clinic
- 88% of Tongan ethnicity patients DNA'd their first clinical appointment
- 20% of Cook Island ethnicity patients DNA'd their first clinical appointment.

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Who wasn't seen?

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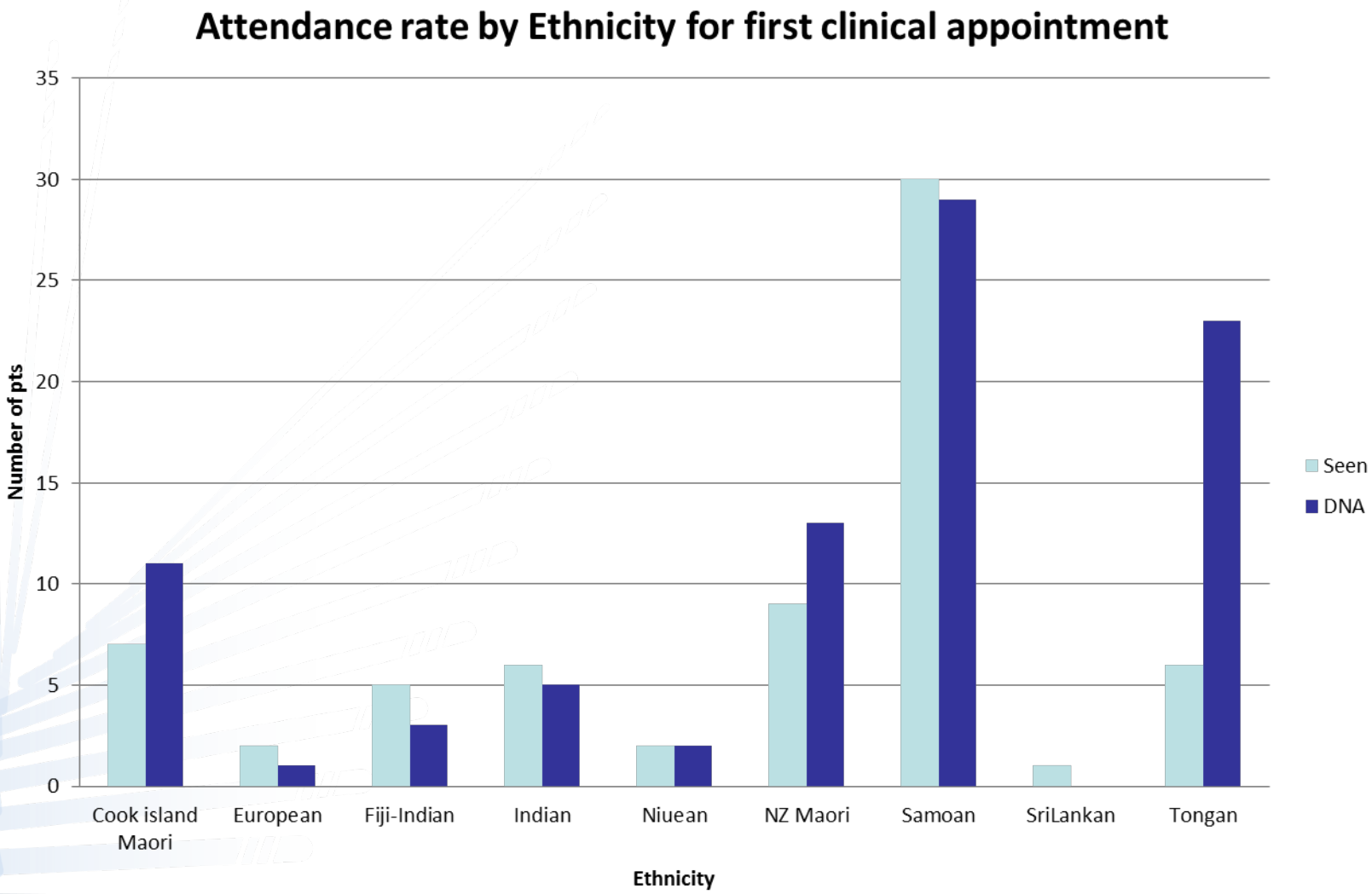
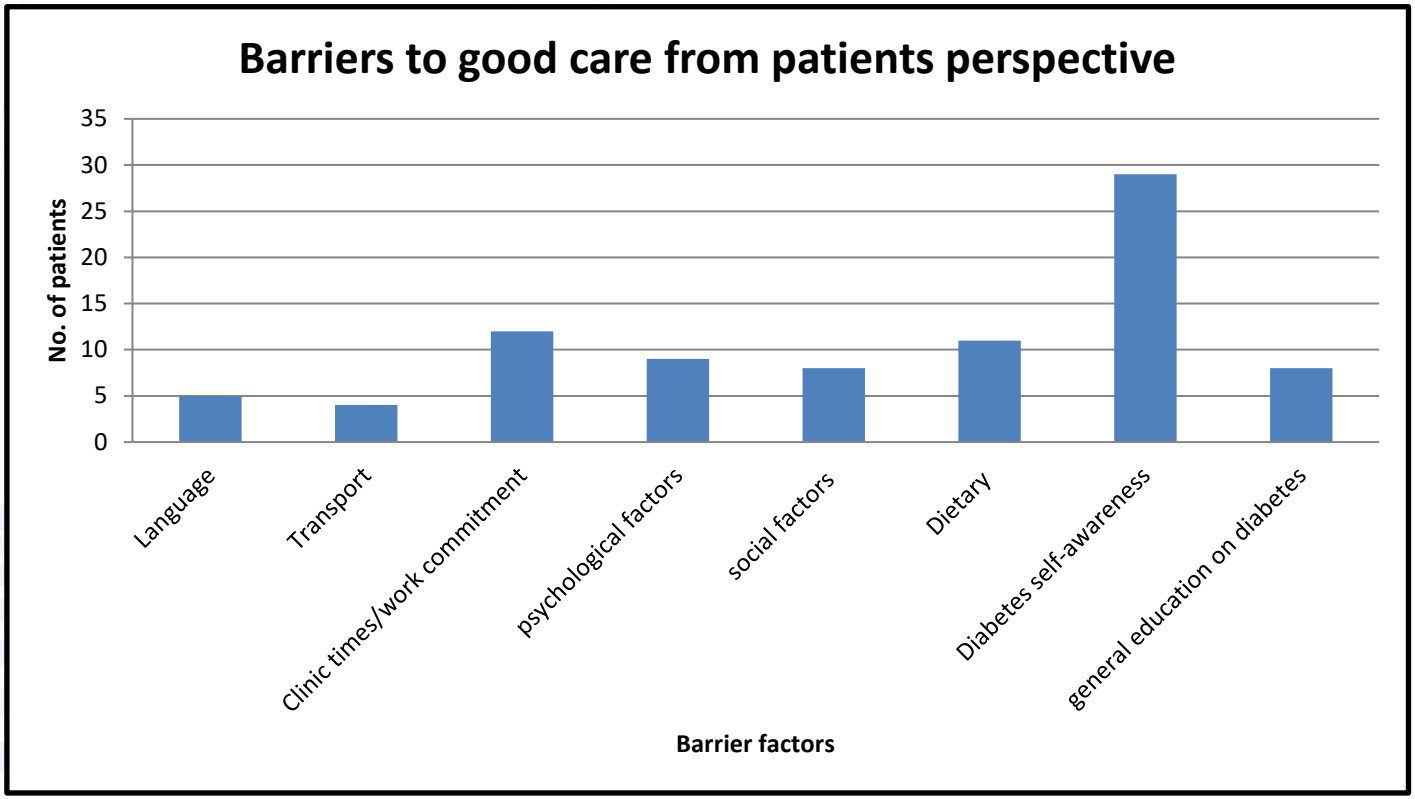


What were the barriers to care?

Diabetes self-awareness was judged the major barrier to care: patients don't know their HbA1c or how serious their diabetes status is



Educated Workforce

- We ran a full day diabetes teaching course
- Attended evening sessions
- Working with health coaches
- Cultural competency – learning from our patients in codesign

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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The traffic light tool

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The traffic light tool

- We tested this resource with our consumers. 10/10 judged this resource as very useful.
- We redesigned the resource to make the red area less dramatic/ threatening and tested our new designs with the consumers. The preference was for the existing design.
- Patients have appreciated using this design with comments like
  "I want to get to the green"

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The traffic light

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HbA1c (mmol /mol)	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
=>120								
115-119								
110-114								
105-109								
100-104								
95-99								
90-94								
85-89								
80-84								
75-79								
70-74								
65-69								
60-64								
55-59								
50-54								
45-49								
40-44								

	<=39 mmol/mol	40-49 mmol/mol	50-59 mmol/mol	60-69 mmol/mol	70-79 mmol/mol	80-89 mmol/mol	90-99 mmol/mol	100-109 mmol/mol	110-119 mmol/mol	=>120 mmol/mol
Date:										
Date:										
Date:										
Date:										

GO GREEN

LIVE LONGER and HEALTHIER

STOP Caution
SLOW Down
GO Keep it up

Name:	Date of Birth:

HbA1c indicator of services users 3-month average blood sugars level.

Control level	Diabetic status	HbA1c (mmol/mol)	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
STOP Caution	Severe risk caution Diabetes	=>120								
		115-119								
		110-114								
		105-109								
		100-104								
	High risk caution Diabetes	95-99								
		90-94								
		85-89								
		80-84								
		75-79								
SLOW Down		70-74								
	Proceed with caution Diabetes	65-69								
		60-64								
		55-59								
Go Keep it up		50-54								
	Impaired	45-49								
		40-44								
	Non-Diabetic	<= 39.9								

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SME attendance

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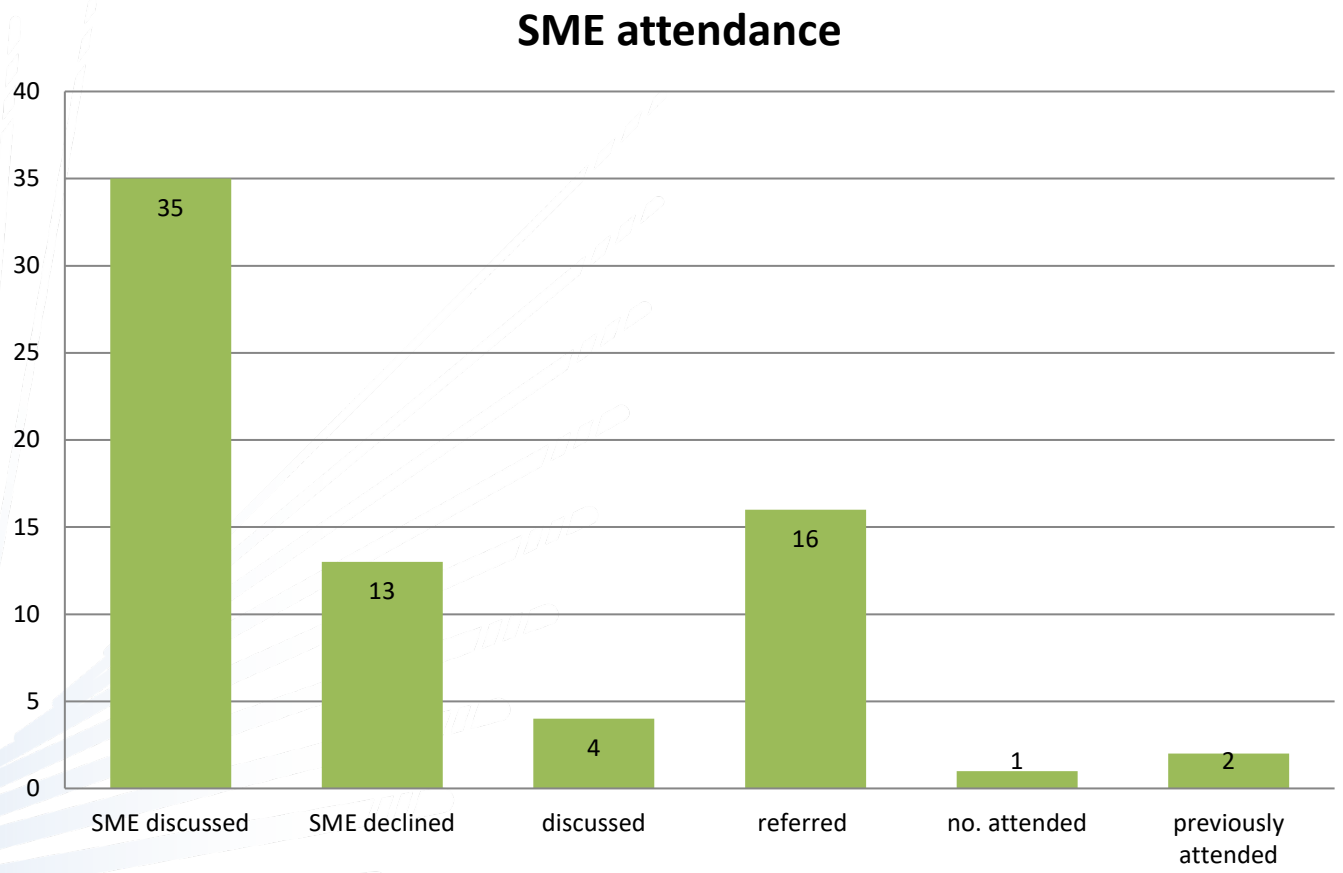

Patient health literacy

Would patients be more likely to attend a group appointments?

group appointment = education session plus some individual time with a clinician

1st session: 15 invited 6 attended

2nd session: 3 attended

Encouraged by the enthusiastic response from the session we tried again using warm calling techniques

1st session: 12 patients invited – 2 attended

2nd session: 9 patients invited – 3 attended

Voice of the Customer

- I have been really naughty. If I don't look after myself I can't look after my husband
- 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've not been taking my medications regularly- I didn't think it mattered too much

Did we make a difference?

- Out of the 44 TEAM patients that we have seen, 27 patients showed improvement in their HbA1c

- Adding up all 44 TEAM patients HbA1c differences there is an improvement of 851 percentage points of HbA1c

Further work

Why are Tongan, Cook Island and NZ Māori patients not coming to the appointments?

Two patients had been champions on the SME course in the past but lost their way again. What happened?

Contacting patients by phone is not adequate. This project needed community worker support.

Barriers/Lowlights

- Appropriate structures and culture within the practice to support the work
- The role of quality improvement, data and audit within primary care
- Developing strategies to use resources including staff in a more cost effective and efficient manner
- Socioeconomic factors that are outside our control

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Highlights

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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

Lessons learnt

There is huge need in our community

Equity is not been addressed

Quality improvement needs a committed team and management support

There is a lot more that needs to be done

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Key Success

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The patient remains central to our work

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.

Future projects

- Warm handovers
- Opportunistic screening
- ?Group appointments
- Know your number campaign - to trial a traffic light tool probably in an opportunistic consultation

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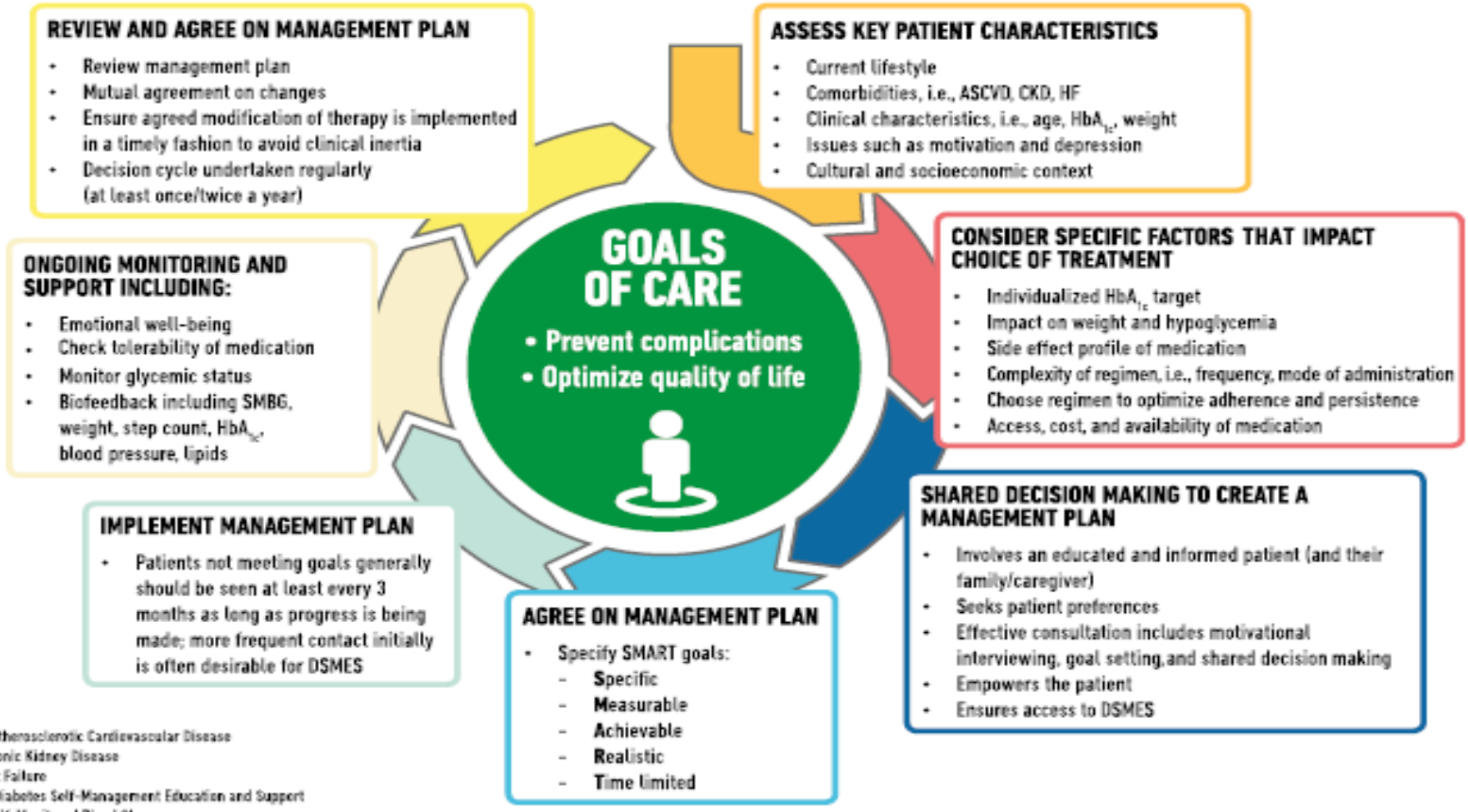
DECISION CYCLE FOR PATIENT-CENTERED GLYCEMIC MANAGEMENT IN TYPE 2 DIABETES



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.