Taumarunui Community Kokiri Trust
He Mate Huka Oranga

Primary Care Improvement Facilitators Programme 2019

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Ko Awatea
Health System Innovation and Improvement

Improvement Facilitator

- Ko Tainui te waka
- Ko Matekana te maunga
- Ko Waitomo te awa
- Ko Pohatuiri te marae
- Ko Ngati Maniapoto te Iwi
- Ko Uekaha te hapu
- Ko Rereahu toku ukaipo
- Ko Aroha Te Tai-Dempsey taku ingoa
- He Neehi me he Whanau Ora Kaiarahi ahau
  no Taumarunui Community Kokiri Trust

Background/Context

- Taumarunui Community Kokiri Trust (TCKT) is a Kaupapa Maori Organisation established 1989
- In 2013 Taumarunui Community Kokiri underpinned all service delivery through a Whanau Ora Integrated Model of Care
- Service Delivery is across the Waikato DHB in the Ruapehu & Waitomo LGA's
- 6779 enrolled clients in our 3 GP clinics
- 506 of these clients aged 45+ years are registered with Diabetes
- 52% are Maori.
- 73 % live in Quintile 4 & 5 areas.
- With a high number of High Needs population, both clinics are VLCA.
- In 2019 all 3 clinics will be under the National Hauora Coalition PHO

Taumarunui Community Kokiri Trust - CORE VALUES

- **Ma Te Reo Maori – Ka Pumau ai to tatau Maoritanga** (language preserves our Maoridom).
- **Manaakitanga –** Caring, sharing and taking responsibility for your impact on others.
- **Wairuatanga** – A Life force within us that determines our own behaviour.
- **Whakapapa** - Acknowledgement and respect of a larger sense of belonging, includes maunga, awa, waka, iwi, hapu, marae, whare, tipuna and ingoa.
- **Whanaungatanga** - Building relationships and recognising the role of whanau relationships in the well-being of the individual.
- **Rangatiratanga** – Acknowledgement of oneself and others by acting with responsibility and integrity.
- **Kotahitanga** – A sense of unity and recognition that everyone has a role that contributes to the whole.
- **Kaitiakiatanga –** Responsibility as worthy guardians of Maori health and well-being
- **Te Tiriti O Waitangi** - Reflecting the role of *Partnership, Participation and Protection*

Demographics

- Enrolled population – GP Clinics (6779)
  - 1142 (Te Kuiti)
  - 2211 (TFC)
  - 3400 (TMC)
  - 26 (DSM – Whanau Ora – Diabetes - Taumarunui)
- Demographics – (6779)
  - European 2624,
  - Maori 3916
  - Pacific I. 117
  - Asian 98
  - Other 24

Improvement Team

- **Our project team is (will be) made up of:**
  1. Aroha Te Tai-Dempsey; Participant + Nurse (Taumarunui)
  2. Mahina Joseph-Small; Participant + Nurse (Te Kuiti)
  3. Grace Orsmby; Participant – Community Health Coach (Te Kuiti)
  4. Siohban Hohepa; Intake & IT
  5. Lynda Bowles; Participant Advocate & GP Manager
  6. Piki Taiaroa; Project Sponsor and organisation Operations Manager

  - **<u>Stakeholders:</u>**
    - Taumarunui Medical Centre – GP Nurses
    - The Family Clinic – GP & Nurses
    - Maniapoto Whanau Ora Centre – GP & Nurses
    - Taumarunui Hospital ED
    - Taumarunui Hospital SPOE

Problem Statement

- Diabetes is our largest and fastest growing health issue we face in NZ and is closely linked to heart disease.
- 506 clients In our 3 GP Clinics aged 45+ years are diagnosed with Type 2 Diabetes.
  - 195 - TFC
  - 202 – TMC
  - 109 – Te Kuiti
- 52% are Maori

Aim Statement

To decrease HBA1c for:

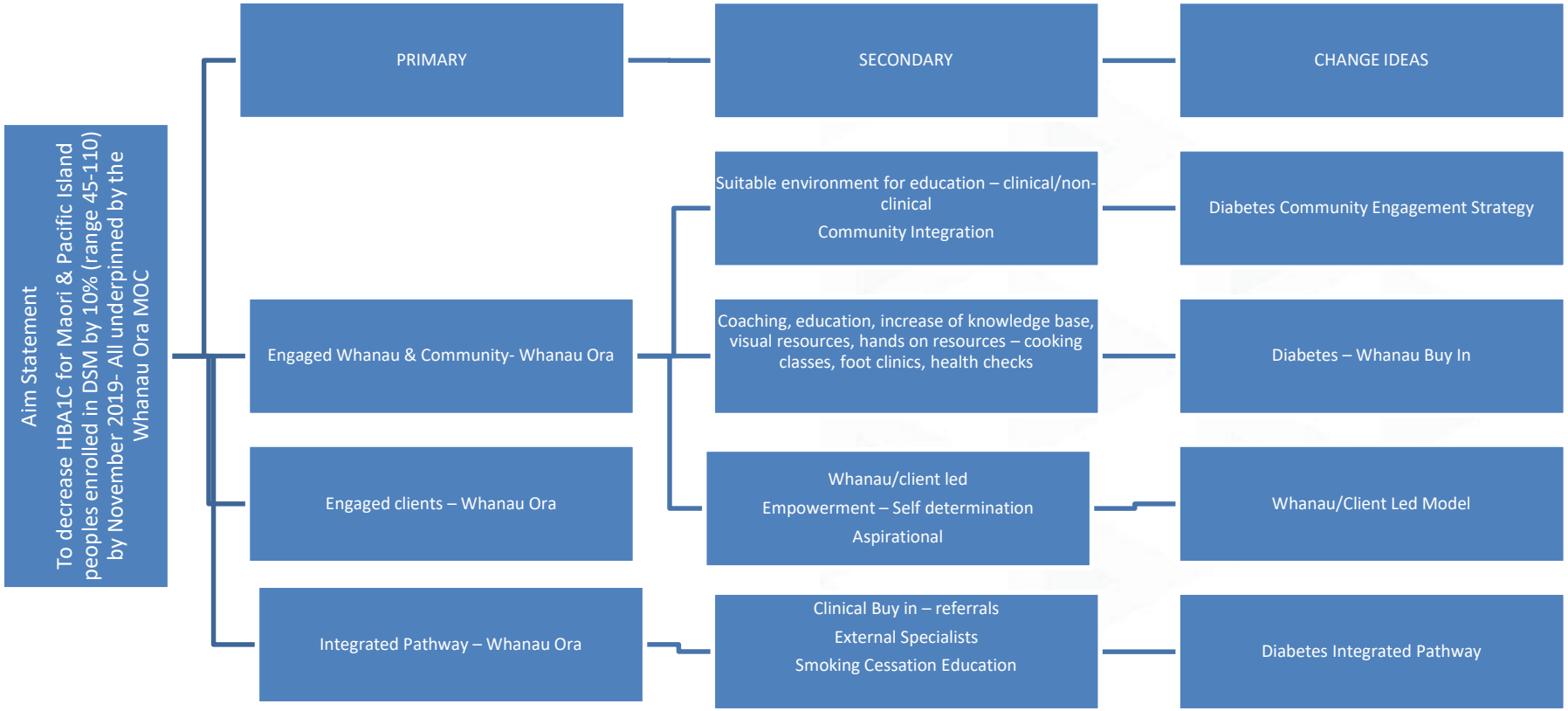
- **Maori & Pacific Island peoples**
- **Enrolled in the Chronic Disease Management Programme (DSM)**
- **by 10% (Range 45-110)**
- **by November 2019**

<u>All underpinned by the</u>

<u>Taumarunui Community Kokiri Trust</u>

<u>Whanau Ora Model of Care</u>

Driver Diagram



Diagnose the problem – data

- Maori are over-represented in the diagnosed Diabetes – Type 2 patients in the GP Population
- HBA1c exceed >40 benchmark by the enrolled GP population
- Low referrals to Healthy Lifestyle Programme – from GP
- 26 patients are enrolled in Chronic Disease Management – all exceed >40 hba1c
  - 6 patients are enrolled in a healthy lifestyle programme

Diagnose the problem – data

- Baseline Survey May 2019
- 142 participants
- 95 Maori
- 1 Pacific Island

- 33 Maori + 1 Pacific Island people want more education
- 25 Maori + 1 Pacific Island people want to attend education programmes in a community setting
- 16 Maori + 1 Pacific Island people want support in a Community Setting
- 4 Maori people felt blamed or judged by their condition

Diagnose the problem- tools

- Whanau Ora Assessment
- Observation
- Chronic Disease Management – clinical & reporting checklists - quarterly
- Annual Diabetes Checks – GP – Reported DSM
- HBA1C >40 – Blood Test - GP – Reported DSM
  - Patients respond to support > 15 min clinical consult
  - Patients improve when engaged in a weekly healthy lifestyle programme
  - Patients are less honest in a clinical consult
- GP Integrated Performance & Incentive Framework (IPIF)
  - DARs TFC – 22 overdue + 85% completed vs national target 90 %
  - DARs TMC – 124 (89 high needs & 62 Maori) due + 78.88% compared vs national target 90%
  - DARs MWO – 22 overdue + 75% completed vs national target 90%

Capturing the Patient Experience

- Waru is a 49 year old man with Type 2 diabetes
- Recently released from Prison
- Lacks Social schools and boundaries
- Chronic renal failure, and essential hypertension.
- Waru, walked from Turangi to Taumarunui (45 mins by car)
- Poor footwear - Open foot wounds – requiring wound care 6+weeks
- Referred to the Whanau Ora Pathway for
  - DSM (Chronic Disease Management)
  - Kaumatua Programme for socialisation and engagement with others
- Waru's aspirations – Whanau Direct application $500
  - Use Gym
    - Requires proper clothing & footwear.
  - Independent living

Diabetes Education & Support clinic

- Diabetes clinic commenced April 2019 - 5 clinics to date
- Nutritional education in a group setting - Reduce Salt!
- Focus on Fluid shift between cells
- Education resources/tools provided to reinforce learning
- Get moving – physical activity for 30-60 minutes
- Weightloss – focus on the wellbeing change rather than the loss
- Introduction of weekly Foot & nail clinic
- Encouragement to attend specialist appointments
- Medication management – supports increased knowledge
- Annual reviews are encouraged:
  - GP
  - DARs
  - Pharmacist

Consumer Engagement (Types)

Type	Engagement timeframe	Cost
GP appointments	15 mins	$18.50
Nurse appointments	15 mins	$10.00
Chronic Disease Management Programme	60+ mins	Free *
Diabetes Clinics	240 mins	Free*
Healthy Lifestyle Programme	240 mins	Free*
* All programmes have a registered Nurse component		

Stakeholders Analysis Date Completed/Updated

Stakeholder	No commitment	Let it happen	Help it happen	Make it happen
GP			X	
	Action/s planned to move stakeholder			
Develop & implement integrated pathway DSM clinics				X
	Action/s planned to move stakeholder			
Practice Nurses		X		
Develop & implement integrated pathway DSM clinics				X
Taumarunui Hospital	X			
Develop & implement integrated pathway DSM clinics				X

Mark the current state for your Stakeholders the desired state and how you plan to keep or move them to the desired state

X = Current State **X = Desired State**

Stakeholder communication plan

Stakeholder	Motivation/values	Action/message	Strategy	Responsibility	Reflection
GP	Improvement of patient health & Less consultations	Integrated Pathway Weekly clinics DSM	Weekly hui promote & update	Aroha/Piki	1/6/19
GP Nurse	Improvement of patient health & less consultations	Integrated Pathway Weekly clinics DSM	Weekly hui promote & update	Aroha/Piki	1/6/19
Taumarunui Hospital ED	Reduced-re-presentation effective primary care management	Integrated Pathway Weekly clinics DSM	SPOE, HWSI	Piki	1/7/19
Taumarunui Hospital Ward	Reduced-presentation effective primary care management	Integrated Pathway Weekly clinics DSM	SPOE, HWSI	Piki	1/7/19

Key Success/barriers

- **Resources:**
- **Data availability:**
- **Time allocated for the project** – 1-2 days per week
- Language

Lessons Learned

- Face to face hui with stakeholders to increase for promoting benefits of integrated model of care utilising baseline data
- Project Team being on the same page
- Dedicating time to the project
- Peer engagement