Primary care improvement case study

Improving eczema management and care at Hauora Heretaunga

Number 12 in a series of 18

Project overview

Hauora Heretaunga developed a quality improvement project to improve the wellbeing of Māori children aged 0–4 years who are suffering physically and emotionally with eczema.

Whānau were invited to have an initial one-hour consultation with the nurse. As part of this consultation, they completed a Flinders Partnership assessment form that covered all aspects of life and allowed them to set goals to improve their overall wellbeing. The nurse provided support and guidance through this process and scheduled contact and follow-up.

Among the whānau who took part in this programme, 84 percent achieved the goals they had set for themselves. In addition, the number of presentations to a general practitioner (GP) with eczema flare decreased.

Background and context

Hauora Heretaunga provides a very low-cost access (VLCA) practice. It meets the health needs of an enrolled population of approximately 6,000, of whom 64 percent are living in low socioeconomic areas and 90 percent identify as Māori or Pacific peoples (which is 61 percent above the average in Hawke's Bay). Our goal is to make a difference to this population by providing access to screening, monitoring and disease-prevention through a kaupapa Māori approach. In the Hastings region, Hauora Heretaunga is the only practice to be open without enrolment criteria. For this reason, the enrolled population of Hauora Heretaunga is growing and is clearly becoming the practice of choice for high-need Māori and Pacific populations.

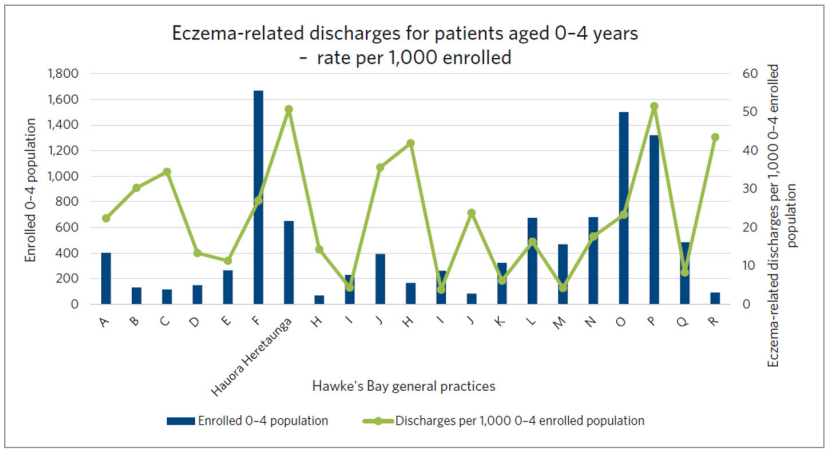
We noted that Hauora Heretaunga patients aged 0–4 years were more likely to be admitted to hospital than patients in the same age group in similar general practices around us. A comparison of eczema-related discharges per 1,000 enrolled population between 2016 and 2018 showed Hauora Heretaunga is consistently higher than other practices. It is not uncommon for our GPs or nurse practitioner to refer eczema for hospital treatment when infected flairs are out of control. Cellulitis and infected eczema are the leading cause of ambulatory hospitalisation for Hauora Heretaunga and seemed to be becoming more common compared with other practices over the previous three years.

Diagnosing the problem

1 What is the problem?

Acute skin infections and eczema in Māori children aged 0–4 years in Hauora Heretaunga, influenced by a lack of self-management support and access to preventative interventions, are resulting in preventable presentations to the general practice and emergency department (ED).

2 What data did you have to describe this problem? What is the significance of this problem in your specific locality and/or practice?



For the three financial years from 2016 to 2018, 46 Hauora Heretaunga patients were admitted to the Hawke's Bay Hospital for eczema and 116 for cellulitis, a total of 162 for that period, which equates to an average of 54 per year for all ages. Hauora Heretaunga patients accounted for the highest rates of admission among all practices over these three years: 5.2 percent of total admissions for eczema, or 8.3 per 1,000, and 4.3 percent for cellulitis, or 20.9 per 1,000. The other two VLCA practices, Maraenui Medical Centre and Totara Health, had the next highest rates.

Problem statement

Hauora Heretaunga has the highest rate of all practices for patients admitted to the Hawke's Bay Hospital with eczema and cellulitis, about 54 per year or 5 percent of the total admissions.

Hauora Heretaunga patients also have the highest rate of presentation to ED with triage 4 and 5 (lower end of five-point ED triage scale). Among these patients, the most common conditions were rash, cellulitis and abscess, representing 14 percent of all Hauora Heretaunga patients, compared with 16 percent of patients presenting with these conditions overall.

The (SMART) aim

For 100 percent of Māori patients aged 0–4 years who have eczema and are enrolled at Hauora Heretaunga on the Eczema Pilot Programme to achieve the Flinders Partnership goal they have set for themselves by March 2020.

The measures

Outcome measure

- Percentage of Māori aged 0–4 years who have eczema and are enrolled with Hauora Heretaunga that achieve the Flinders Partnership goals they set themselves by March 2020.

Process measure

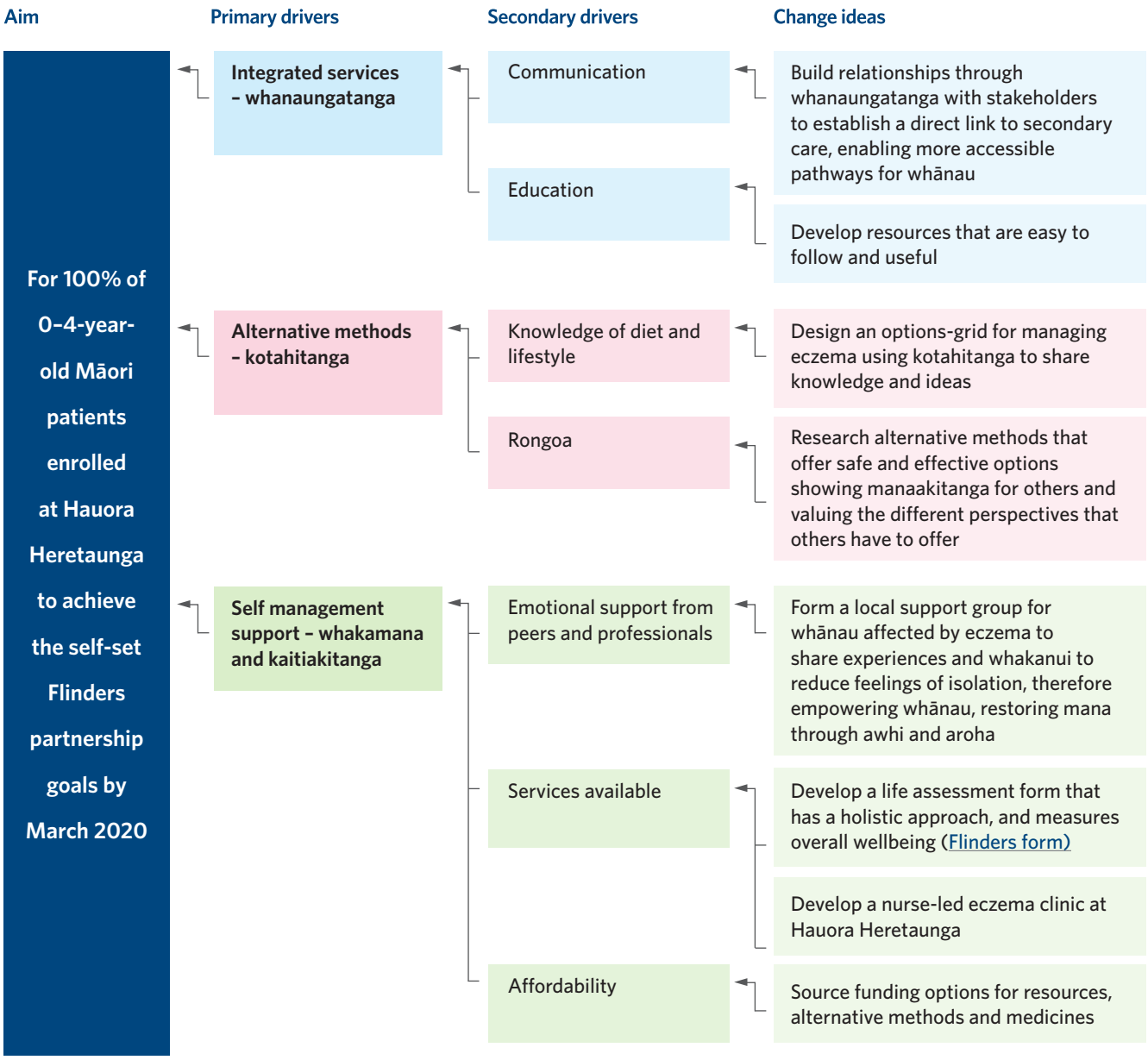
- The number of presentations to ED or GP with eczema flare.

Balancing measure

- Nurse time lost due to patient booked in the clinic not arriving.
  (Time measured is time they could have seen other patients.)

Drivers of change

Driver diagram



What did you do?

1 Were there any ethical considerations to be aware of?

There were no ethical considerations from a project perspective. We did have to consider a desire among whānau to try alternative medicines or rongoā to help with the treatment of the eczema. It was understood that this involved whānau sharing their ideas and thoughts and making their individual choice to try it, rather than staff giving clinical advice or guidance on the subject.

2 What aspects of the project were co-designed with consumers?

After consultation with a focus group, we agreed that whānau would like to form a support group for the purposes of supporting and sharing relatable kōrero with one another. A support group gathering was held.

3 How did you involve consumers in co-design? What processes did you use?

To help diagnose the problem, we worked with a consumer focus group.

- We invited whānau suffering with eczema to come and share with us what worked and what didn't work for them in managing eczema with their little ones. We gave each of them a pen and sheet of paper, so they were able to express their thoughts and experiences freely. This worked very well, enabling us to see what they had written and then explore any issues with them further.
- After this session, we started to develop some change ideas we thought would support them in their self-management of eczema.
- We invited the focus group members back to reaffirm that we had heard their voices and were on the right track to developing something together that would help them.
- We continue to work with consumers throughout the journey.

Eczema clinic team and whānau

4 What quality improvement tools did you use, that you would recommend?

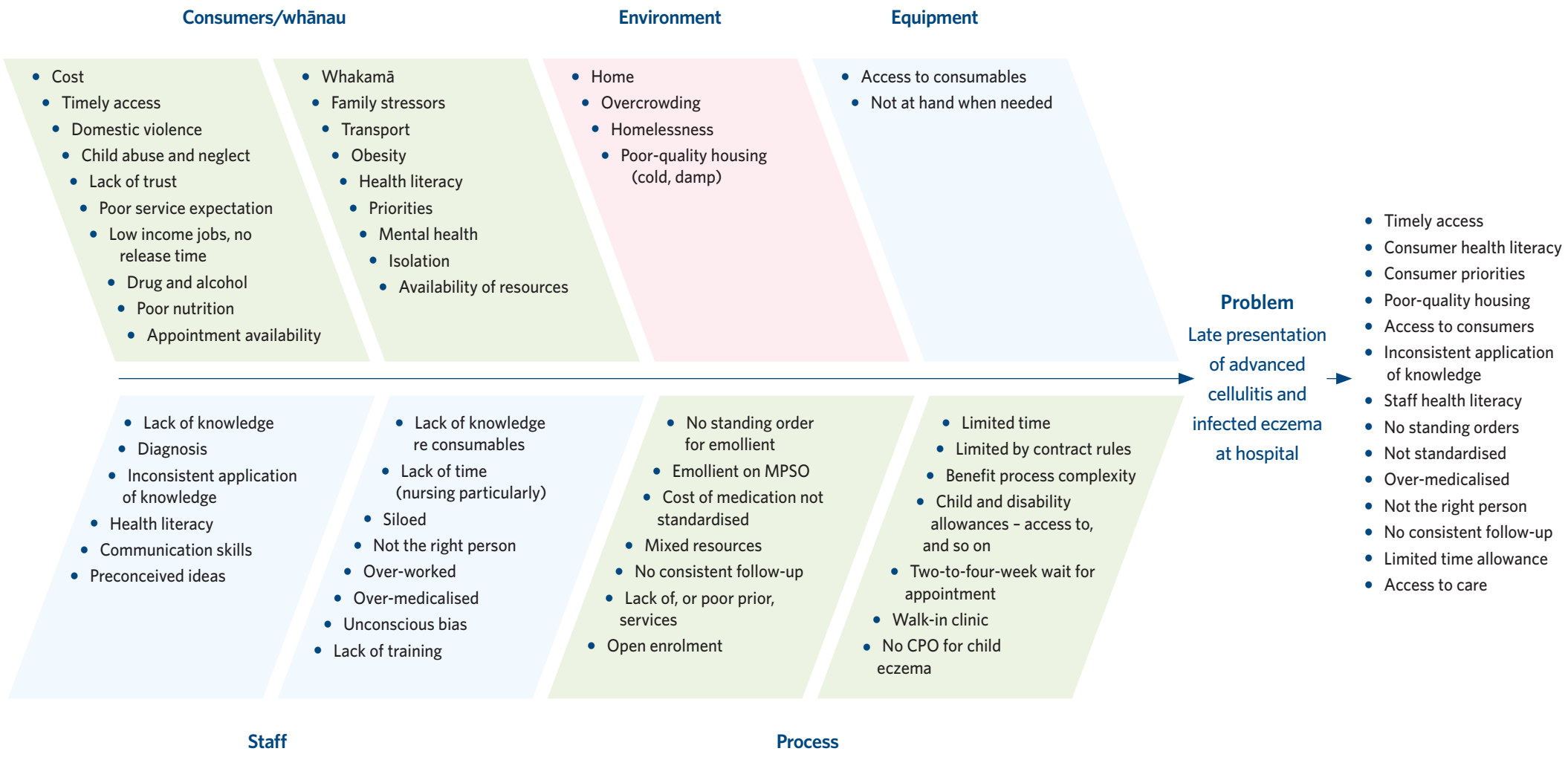
Process mapping

To help us identify places in the process where there was waste and an opportunity to improve, we mapped the patient journey from diagnosis through a hospital admission after a flare and back to GP care. Our team got together and used Post-it sticky notes on the wall to collect data from team members about the patient journey from a clinical perspective.

Fishbone diagram

We isolated several areas for improvement during a meeting held with the multidisciplinary team. The team then rated these areas to identify the initial priorities to address. Areas of significance included: health literacy; standing orders for emollient cream; standardised processes; and timely access. This project will work on improvement activity in these key areas. The team did consider other areas such as housing; however, these may be outside the direct control of the project. The fishbone analysis displays the areas that we identified.

Fishbone diagram



Note CPO = coordinated primary options MPSO = medication prescription standing order

PDSA and testing the use of SCORAD[1] to measure patient progress

SCORAD (SCORing Atopic Dermatitis) is a clinical tool to assess the extent and severity of eczema, which gives an indication of whether treatment has been effective. We tested it using the PDSA cycle.

- **Prediction**: Patients would identify eczema triggers of areas of difficulty that the team could address.
- **Plan**: Test the use of SCORAD with two staff. Use the SCORAD assessment form and recall patients twice fortnightly to review their progress.
- **Do**: Staff had trouble making contact with patients and were unable to complete the reviews.
- **Study**: Fortnightly reviews were not completed because that was too frequent for the whānau. However, they were not presenting with flares. That initial presentation where they received advice and education was sufficient to see an improvement in their eczema management.
- **Act, adapt:** Continue with follow-up as able, but not fortnightly and more on the telephone than face to face. Monitor practice and ED data for flares. Patients are now calling straight through to the nurses for follow-up as they have established the direct relationship.

What changes did you test that worked?

- Use of Flinders assessment tool
- Local support group
- Nurse-led eczema clinic
- More accessible pathways
- Establishing a relationship with the hospital paediatric nurse leading eczema management. Through this we gained access to advice, education for our nurses, fast-track referrals and use of their resources.

[1] dermnetnz.org/topics/scorad/

The results

1 What outcome measures improved?

Māori patients aged 0–4 years who had eczema and were enrolled at Hauora Heretaunga on the eczema pilot programme achieved the Flinders Partnership goal they set themselves to achieve by March 2020.

So far in the project, one aspect that whānau agree on is that they appreciate dealing with one practitioner in managing eczema. It makes them feel listened to and they build a relationship with that person in which they feel comfortable and open in consultations and need not repeat their story multiple times. In this way the practitioner can help them with not only the eczema but also the other issues within their lives, giving wraparound care.

The greater confidence in managing the eczema has been another message that has come through strongly. Whānau feel confident also in sharing their knowledge with others. In addition, having good experiences in the clinic has increased their trust in the other professionals that they are dealing with, where they didn't necessarily have trust before.

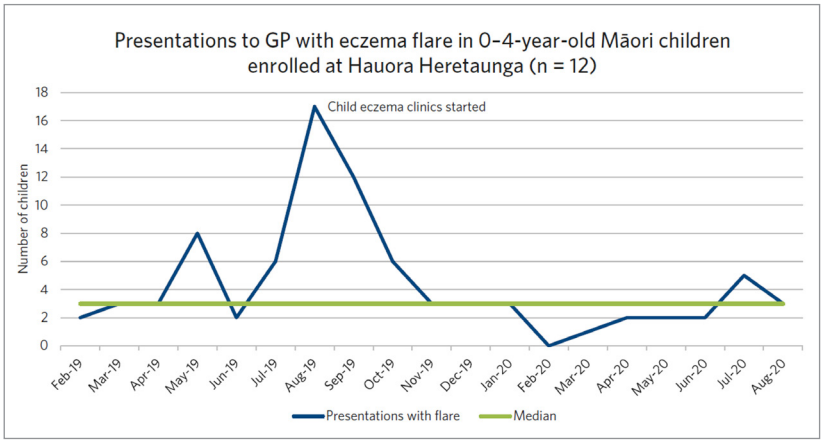
2 What equity measures improved?

All the whānau we worked with were of Māori or Pacific descent. Integrating with the other services made it possible to address dental outcomes, cervical smear testing and historical abuse issues.

Comments from whānau included:

- Coming in to see Helen was very helpful she explained to me how to use the steroid cream properly, I was to scared as I had listened to the opinions of others so when I listened to her explain it to me it made sense and I am now using it on my baby and it is really helping. She also gave me a handout to refer to if I forget or had any other queries. She made me feel comfortable enough to ask questions without being embarrassed. When I call the clinic I ask to speak with her as she knows my story.
- Dealing with eczema has been a lot of trial and error. In my previous practice it was as though they didn't want to take the time to explain things to me so I would search for answers myself. When I came to Hauora Heretaunga I found the nurses so helpful in explaining things to me in a way I could understand, they gave me little tips to use that I found very helpful. Eczema is draining emotionally and mentally but I feel like since I have been with this clinic, I am on top of it.

3 What process measures improved?



4 Were there any unintended consequences such as unexpected benefits, problems or costs associated with this project?

- **Whānau** have gained:
  - stronger relationships with practitioners. This has allowed the practitioners to work in a pae ora model to refer whānau to appropriate services that could address, for example, oral health care, overdue cervical smears, historical abuse issues, Whānau Direct applications and Child Disability Allowances
  - gained greater confidence and motivation, meaning they are proactive in accessing clinic for skin review and medications instead of presenting with eczema flare only, as they had been doing previously.
- **Providers** have:
  - increased knowledge through the time they have spent with whānau, who have shared their stories and experiences of challenging mainstream options and the limited choices available
  - improved ongoing relationships and better integration with secondary care services. Through their improved practice and specialist communications, whānau have more options for how to receive care.
- The **organisation** is implementing quality improvement systems aligned with Ngākau Aotea.

5 Is there evidence that the knowledge of quality improvement science in the team or in the wider organisation improved?

The knowledge of quality improvement science has improved within the project team, who have in turn shared their knowledge with the wider team. We have team huddles every day where we share new knowledge with the whole team.

Post-project implementation and sustainability

1 Have the successful changes been embedded into day-to-day practice? How have you managed this?

The changes made in the project are still being embedded among the staff more generally, through sharing knowledge and increasing awareness.

2 How did you communicate your progress and results to others?

- We hold daily team huddles.
- The new Ngākau Aotea model of working enables inter-professional communication and sharing knowledge and awareness.

Summary and discussion

1 What were the lessons learnt?

Many lessons learnt by team members have been personal, for example, applying the tools to everyday mahi and realising they have become a part of normal thought patterns.

The team's learnings have given them great life skills.

The Health Quality & Safety Commission improvement advisor also provided valuable support for the project and it was great for the team to have someone so approachable and ready to help available.

2 Are there any future steps or ongoing work that you are intending to continue with on this project topic?

- Do testing cycles every three months to test reliability against seasonal effects.
- Given our cohort was small, consider replicating the approach across a group of practices.
- Test for effectiveness and possible duplication of effort.
- Use PDSA cycles in training wider staff.
- Build a model that retains the trust with clients.

The team

Rachel Pere, improvement facilitator

Helen Gosman, nurse practitioner

Julia Ebbett, general manager Hauora Heretaunga and project sponsor

Davina Te Ngahue, nurse

Teamwork tips

- Set aside dedicated time to meet and do not book over it.
- Meet more regularly to communicate and touch base formally as well as informally.
- Do not procrastinate.

Appendix 1: Flinders assessment form

Partners in health scale

Name _____ **NHI** _____ **Date** _____

Please circle the number that most closely fits for you

1 Overall, what I know about my health condition/s is

0	1	2	3	4	5	6	7	8
Very little				Something				A lot

2 Overall, what I know about my medication/s and treatment/s for my health condition/s is

0	1	2	3	4	5	6	7	8
Very little				Something				A lot

3 I take medications or carry out the treatments asked by my healthcare team

0	1	2	3	4	5	6	7	8
Never				Sometimes				Always

4 I share in decisions made bout my health condition/s with my healthcare team

0	1	2	3	4	5	6	7	8
Never				Sometimes				Always

5 I am able to deal with health professionals to get the services I need that fit with my culture, values and beliefs

0	1	2	3	4	5	6	7	8
Never				Sometimes				Always

6 I attend appointments as asked by my healthcare team

0	1	2	3	4	5	6	7	8
Never				Sometimes				Always

1 of 2

Appendix 1: Flinders assessment form continued

7 I keep track of my symptoms and early warning signs (such as blood sugar levels, peak flow, weight, shortness of breath, swelling, pain, sleep problems, mood)

0	1	2	3	4	5	6	7	8
Never				Sometimes				Always or not needed

8 I take action when my early warning signs or symptoms get worse

0	1	2	3	4	5	6	7	8
Never				Sometimes				Always

9 I manage the effect of my health condition/s on **my daily physical activities** (such as walking, hobbies and household tasks)

0	1	2	3	4	5	6	7	8
Not very well				Fairly well				Very well

10 I manage the effect of my health condition/s on **how I feel** (my emotions and spiritual wellbeing)

0	1	2	3	4	5	6	7	8
Not very well				Fairly well				Very well

11a I manage the effect of my health condition/s on **my social life** (how I mix and connect with others and in my personal relationships)

0	1	2	3	4	5	6	7	8
Not very well				Fairly well				Very well

11b I have enough support from my family/whānua or carers to manage my health

0	1	2	3	4	5	6	7	8
Never				Sometimes				Always

12 Overall, I manage to live a healthy lifestyle (I don't smoke and I am not a heavy drinker, I eat healthy food, do regular physical activity, manage my stress and sleep well)

0	1	2	3	4	5	6	7	8
Not very well				Fairly well				Very well