IMPROVING ACCESS TO CARE AND THE JOURNEY FOR MĀORI AND WHĀNAU WITH DIABETES

West Coast PHO:

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

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

Ko Awatea
Health System Innovation and Improvement

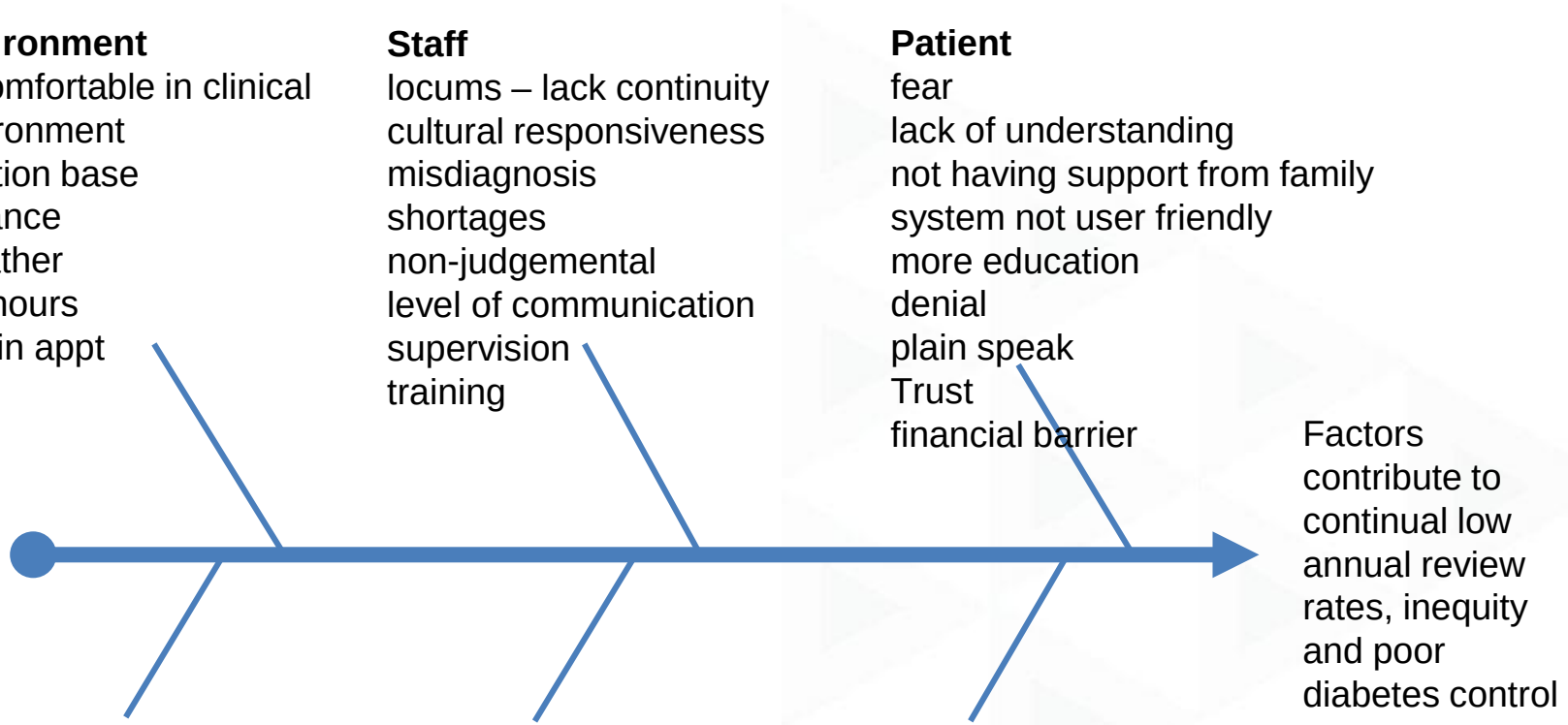
Problem Statement

- **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 (109) with poor diabetes control (HbA1c >64)

Aim Statement

To reduce the average HbA1c level of Māori patients at Buller Medical with diabetes and an HbA1c above 64mmol/l by 20% from 93mmol/l to 74.4mmol/l].

Diagnose the problem- Ishikawa Diagram



Diagnose the problem- Affinity Diagram

- Improved care coordination and delivery
  - Wrap around services
  - Quality of appointment
- Timely access
  - ADRs completed on time
- Improved patient experience and relationship
  - Continuity of care with the same clinician
  - Education packages provided
  - Lifestyle opportunities discussed and referred
- Accurately identified population

Capturing the Patient Experience

- Whakakotahi regional stakeholder meeting - consumers present - 2 local diabetic patients one who is chair of local consumer working group
- 2 Māori consumers on project team – involved in PDSAs
- Patient questionnaire – 35 patients surveyed about DAR experience – at the start
- Continued patient feedback post intervention

Storytelling: the voice of the patient

- Very satisfied with the nurses and DAR
- Like to see the same doctor or nurse
- Feel involved in decision making
- Want more information on medications and side effects, diet, exercise, foot care, diabetes and supports available in the community
- Know what they should/shouldn't be doing

Building up a change package:

Increase Lifestyle programme referrals

- staff education
- Advertising/newsletters
- Retinal screening clinic
- **Single point of entry/triage**

done

SECO training for nurses

- Diabetes cases - **done**
- Foot care
- Motivational interviewing
- Health literacy – **done**

Patient education package/s

- **Medication leaflets** - **done**
- Foot care leaflets
- Healthy eating/label reading

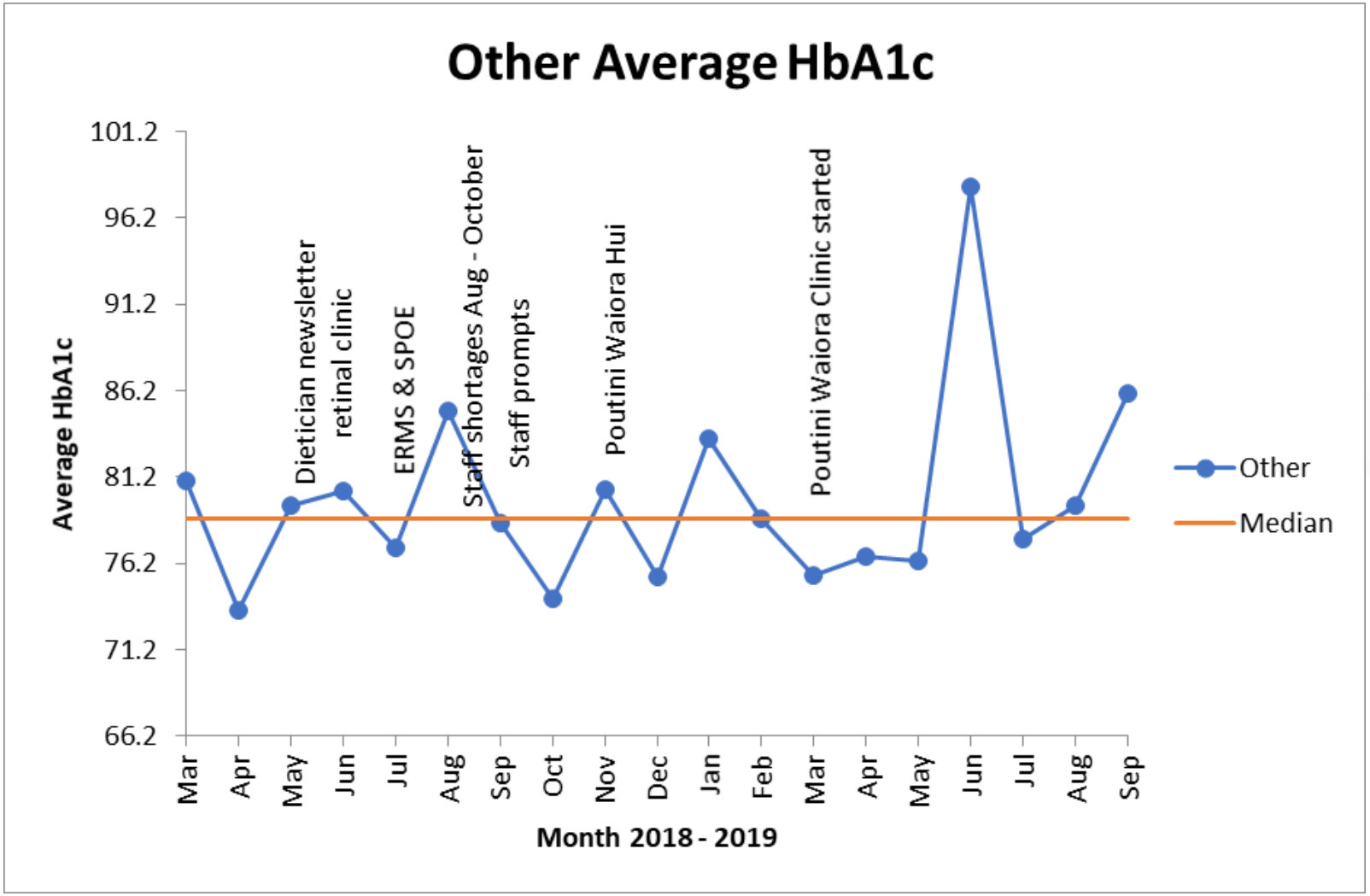
Update Diabetic annual review form

- Update DAR form - **done**
- Medication Audits
- Align PHO/Pharmacy LTC – **underway**
- Pharmacist support in practice – MURs

Increase appointments

- Drs phone triage
- Patient portal
- HML phones
- E-prescribing - **done**

Outcome Measure: HbA1c



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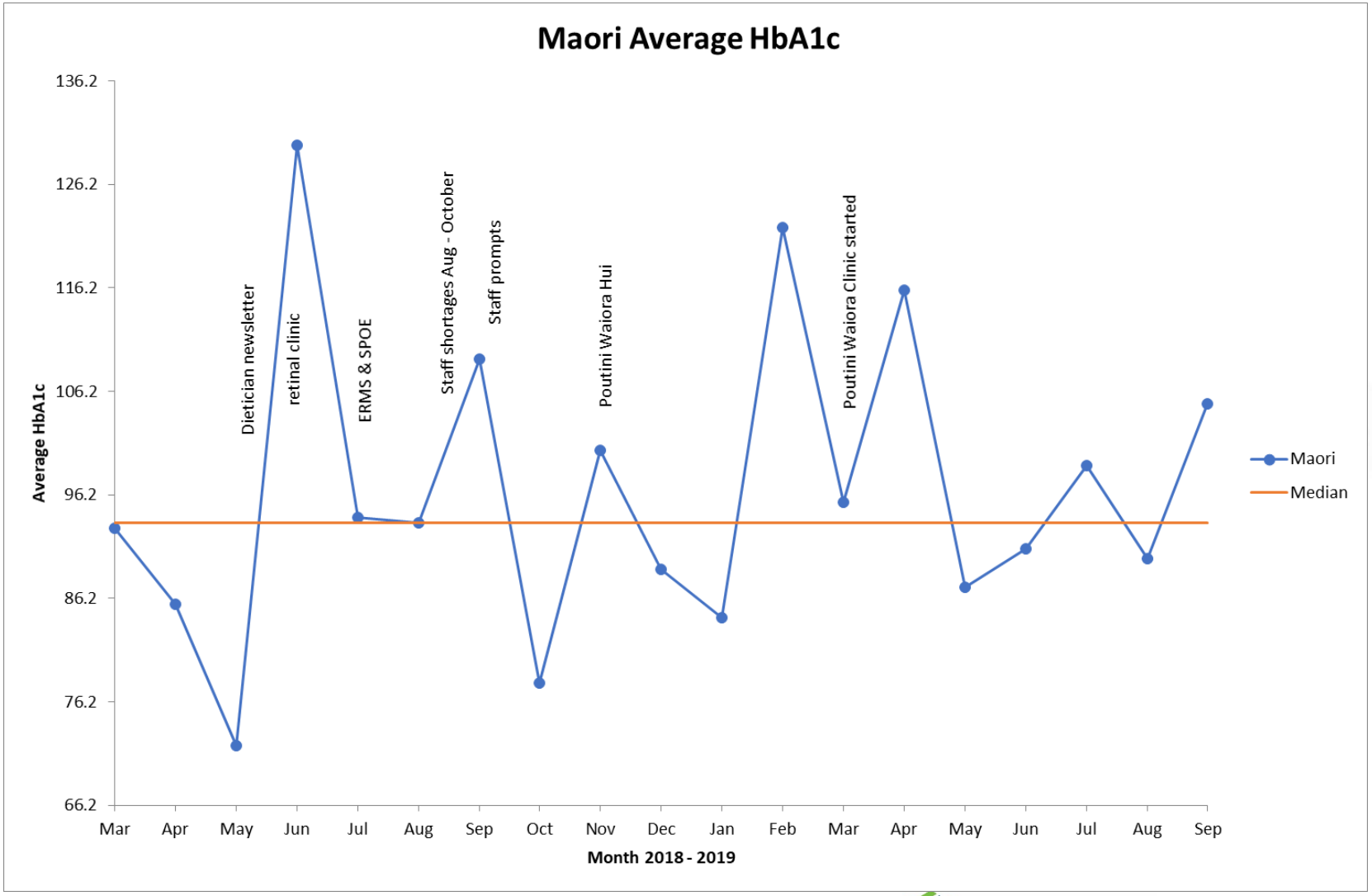
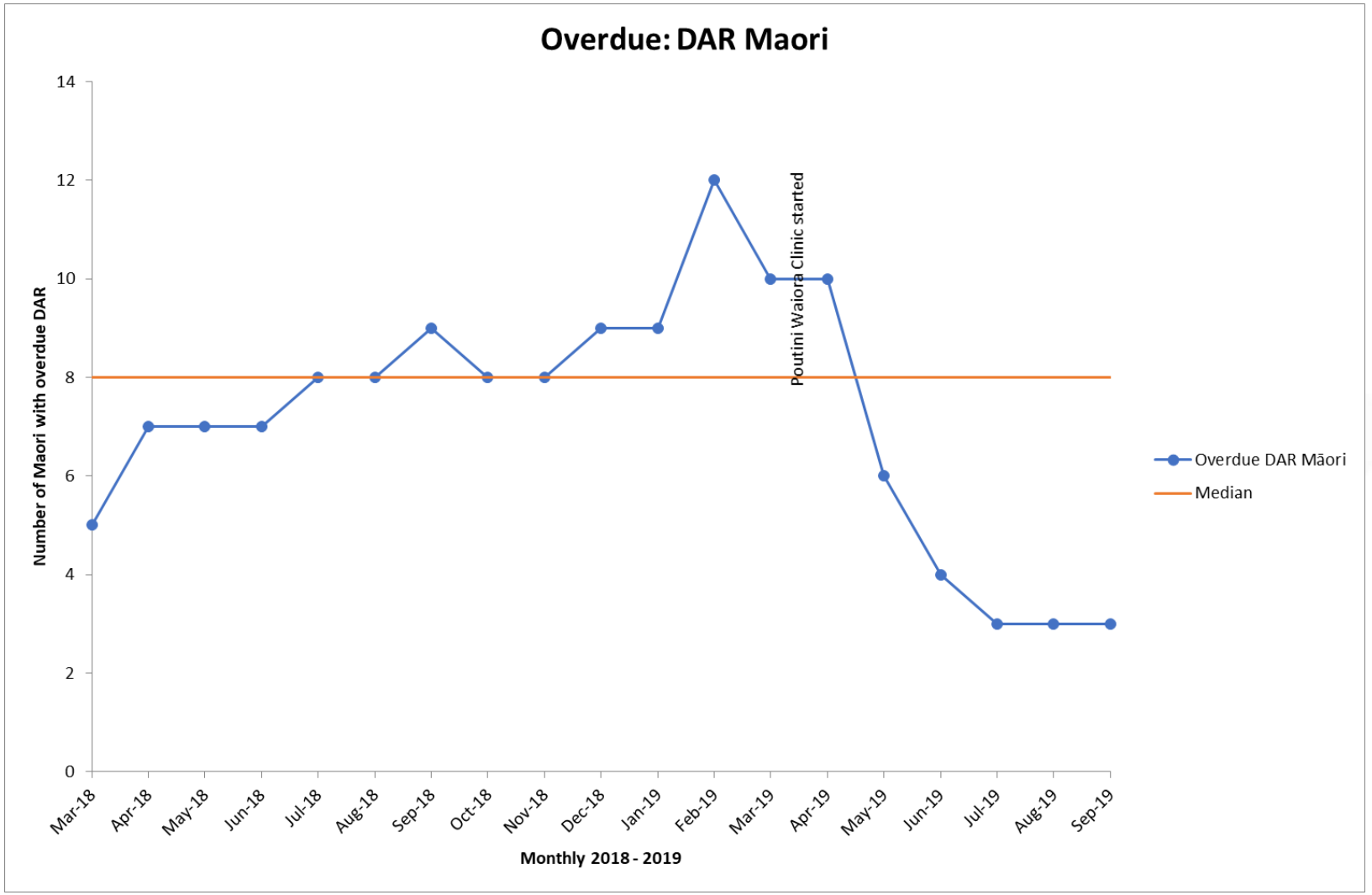
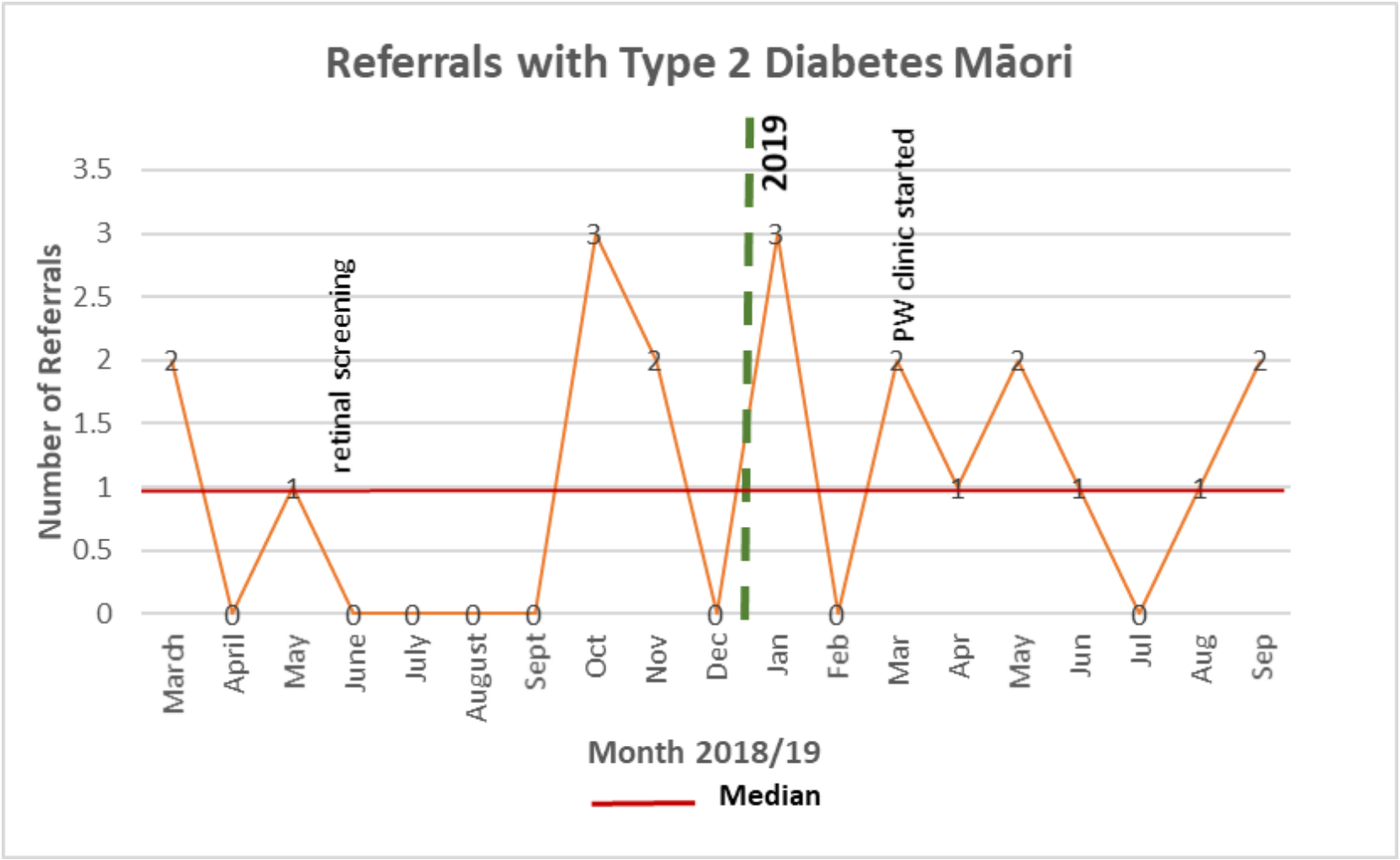


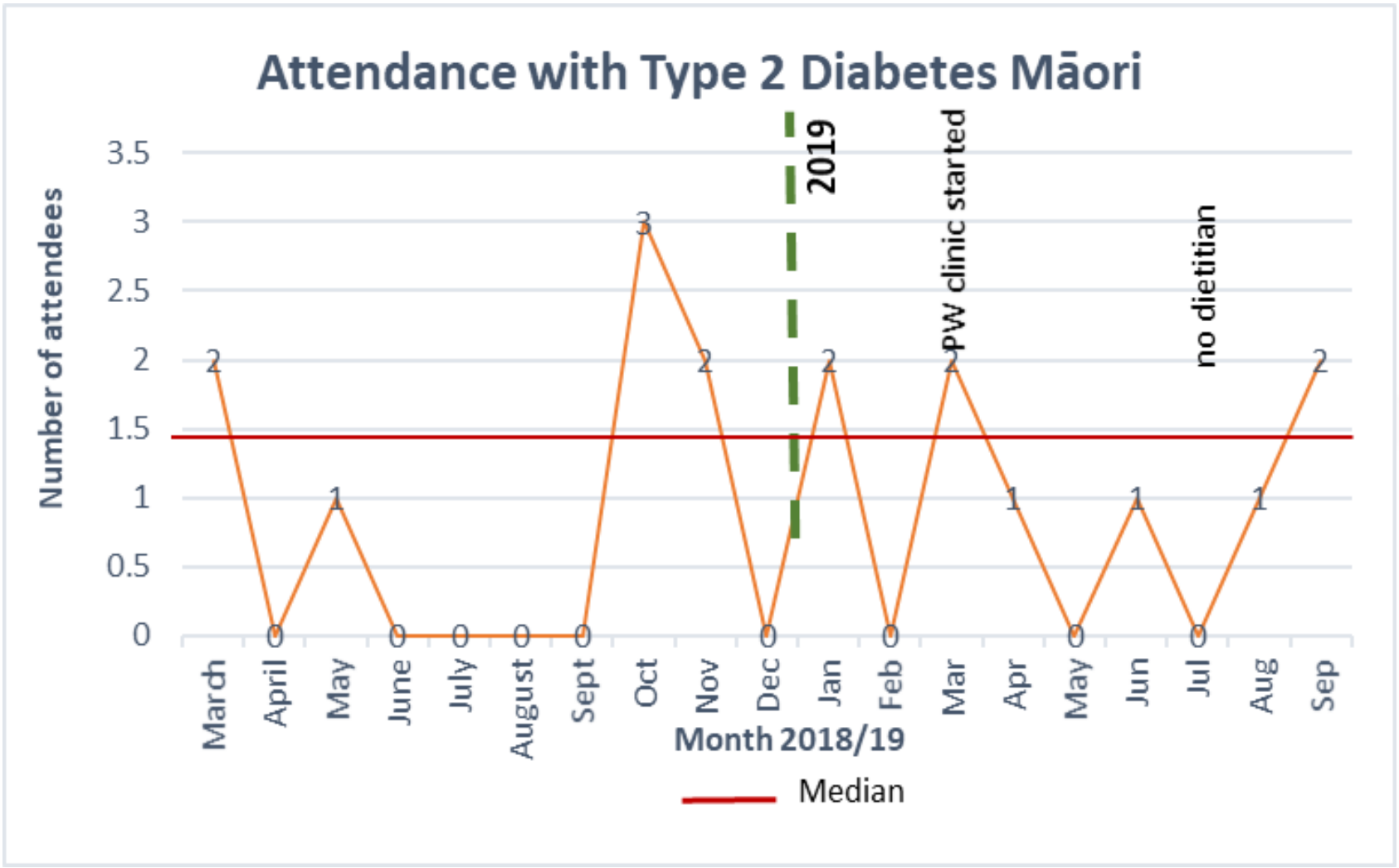
Process Measure: overdue DAR



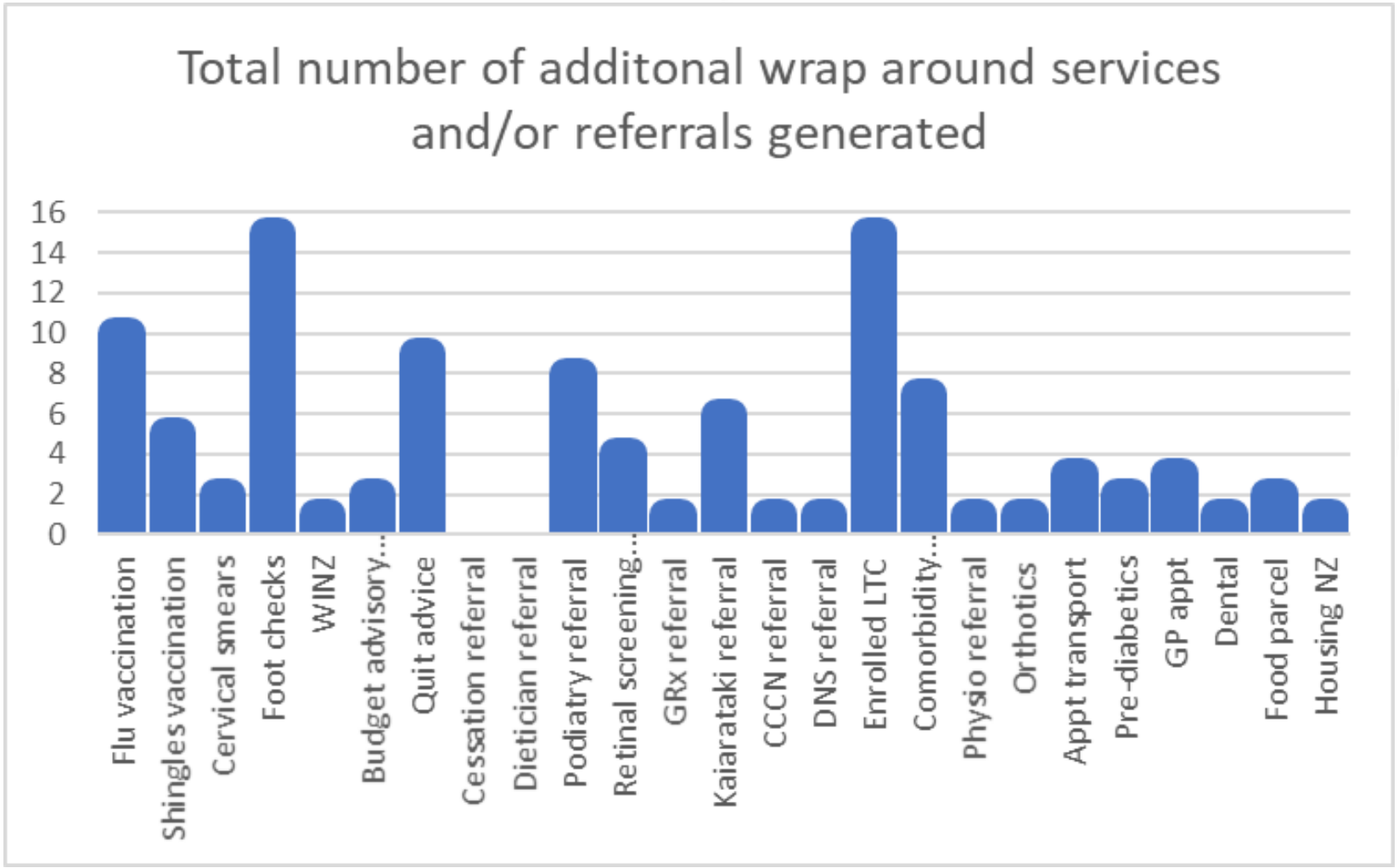
Process Measure: Lifestyle T2



Process Measure: Lifestyle T2

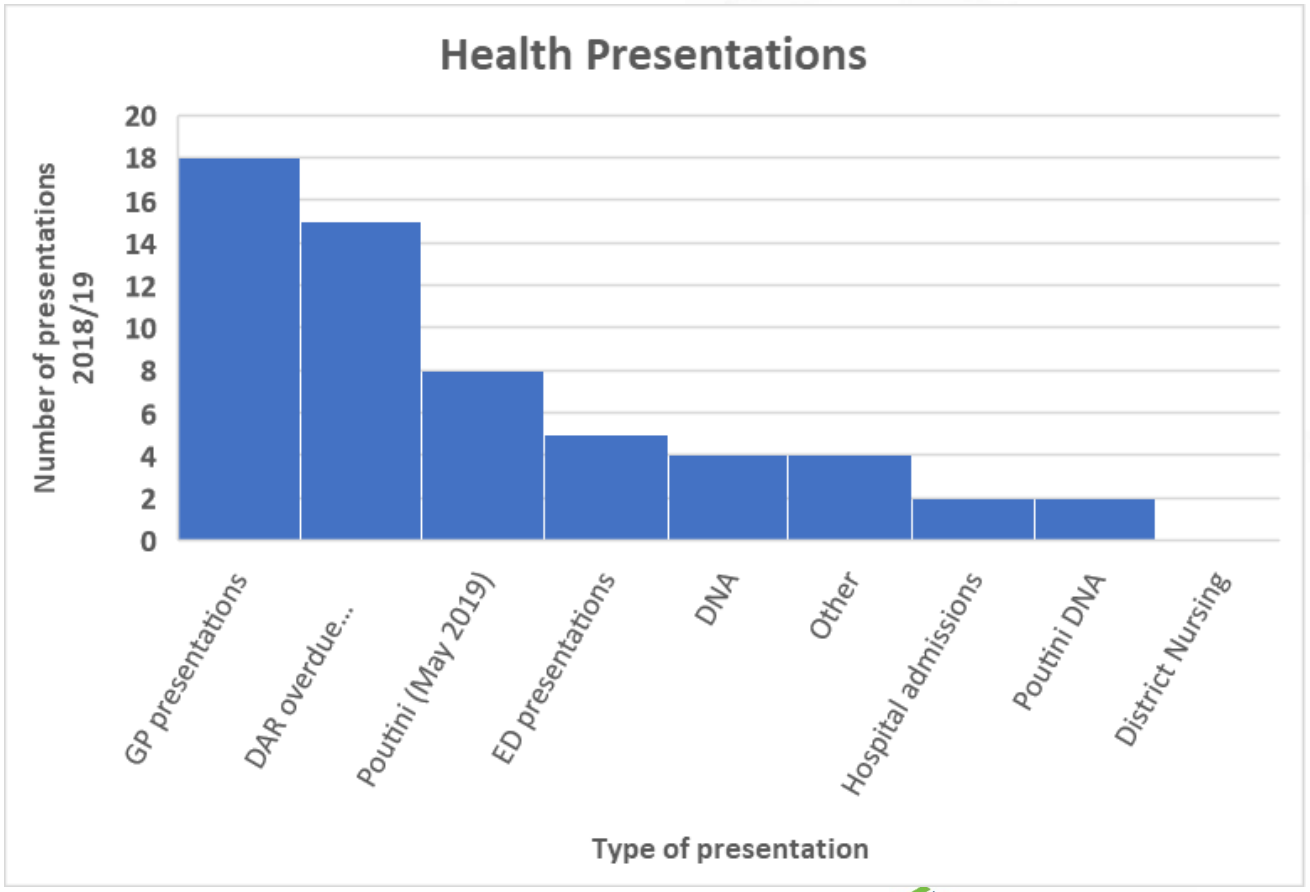


Process Measure: Whānau ora



Jan 2018 – Jun 2019 Case 1

Mental health and anxiety – seclusion (DNAs), wouldn't answer phone or respond to texts, has mobility issues.



Case 1 Outcomes

- Referral to PW for support
- Home visits, completed survey about this experience.
- Patient has **self-increased insulin to improve BGLs**, engaging with PW and answering calls and text messages.
- **Has decreased hours with mental health since gaining support from PW and with improved well-being**.
- Supported to orthotics and got shoes for walking – comfortable for walking outside now. Attended physio, now has taxi chits, mobility parking sign.
- **Beginning to increase independence and self-care with tasks**.
- Attended retinal screening clinic, on recall in 6 months.
- Phones to cancel appointments rather than just DNA.

Case study 1 patient feedback:

- *“Very comfortable…full review”*
- *“Poutini is all about whanau and from previous experience there was little or no care. Poutini offers so much support.”*
- *“Because of PW I now manage my diabetes so much better and happier to do so.”*
- *“It impacted me in a more positive light, therefore my whanau is greatly impacted.”*
- *“Nothing could be improved. PW has been extremely supportive in my mental and physical health.”*
- *“Medication sheets were helpful and easy to understand.”*

Challenges

- Staff shortages (staff turnover / winter crisis)
- Maintaining momentum (protected time and practice engagement barriers)
  - Funding / resourcing the model,
  - Data (obtain manually and prone to flaws through practice user error),
  - No time allocated by practice
  - Buy in from wider team,
  - Sponsor / manager support,
  - Practice environment and culture,
  - IT – just obtaining data
  - Rapid changes across Buller Health

Key Successes

- **Poutini Waiora saved the day!**
- **Engaging GP / weekly case reviews**
- Team inspired
- Positive patient feedback
- **Continuity of care**, holistic wrap around support improving **patient wellbeing and independence**
- Engaged some difficult to engage patients
- **Reduction in overdue DARs**
- **Spread** – Reefton and Greymouth*
- **Spread** – other LTCs
- Alliance Leadership Team (ALT) support for the model for High Need groups and address diabetes in workstreams

Lessons Learned

Process:

- Keep it simple, go slow (while maintaining progress)
- Learn to approach change methodically
- Team learning about quality improvement
- Staff and patient co-design – added value
- Instrumental to involve project in workstream plan

People:

- Need most influential people involved – Kaiarataki / Kaupapa Māori nurse / DNS / GP
- Continuity of care, structured approach and time to provide wrap around care are key (Kaiarataki role)
- Patient stories motivate people
- Going through medicines and health literacy in a way they understand makes a big difference

The End – but only the beginning