Key improvements in Diabetes Care at Capital & Coast DHB since “Get Checked” ended in 2012

PHARMAC October 2016

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Overview

• Capital & Coast DHB
• Drivers for change
• Referral rates to Diabetes Service
• What was happening in 2012
• Diabetes Care Improvement Plan (DCIP)
• Diabetes Nurse Practice Partnership (DNPP)
• The future
Capital & Coast DHB

Facts and figures

300,000 people live in the CCDHB district
- Wellington City
- Porirua
- Kāpiti Coast.

Specialist tertiary services are provided - for 900,000 people

Ethnic breakdown is
- Māori (11%)
- Pacific (7%)
- Asian (12%)
- Other (70%)
Drivers for change

Population
• ↑ Number of people with Diabetes
• ↑ Aging population
• ↑ Complexity/co-morbidites
  – Inpatient role

Other
• Research e.g DCCT/UKPDS
• Technological e.g PHARMAC
  Insulin Pumps -Sept 2012
  Meters/CGMS
• Ministry of Health Funding
  2012 “Get Checked” ceased
Many challenges to working differently ...

- Political - working across services
- Patch protection
- Distrust
- DHB deficit – pressure on innovation
- Funding models – need for flexibility
- Mixed model of practices
  - Business model v’s low cost access practices
Paediatric Referrals
2008 - 2015

- new Type 1
- new type 2
- new pre-diabetes
- new CF-related diabetes
- new neonatal diabetes
- new MODY
- diabetes from pancreatitis
- hyperinsulinaemia
- total new/year

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA
# Diabetes in Pregnancy

## Diabetes in Pregnancy Service Breakdown from June 2009 - July 2016

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<td>TOTAL EPISODES</td>
<td>896</td>
<td>956</td>
<td>1111</td>
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<td>1139</td>
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![Chart showing diabetes in pregnancy service breakdown from June 2009 to July 2016](chart.png)
End of “Get Checked” 2012 – an opportunity

CCDHB Percentage of People with Diabetes with HbA1c ≤8 (64mmol/mol)

Challenged services to

“deliver better, sooner, more convenient and integrated care for people with diabetes”

To be delivered through Primary Care with support from Specialist Diabetes Services
Wagner’s Chronic Care Model 1998

The Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes

- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions

Developed by The MacColl Institute
® ACP-ASIM Journals and Books
Diabetes Care Improvement Plan

Key factors for success

- **Organizational support** - Astuti Balhram project lead
  - Stakeholders agreed to a collaborative approach
  - Vision & commitment to working together
- **Delivery System Design** – flexible, yet targeted
- **Used Clinical Information Systems** - to allocate resources e.g nursing time
- **Decision Support** – commencing insulin in Primary Care - a marker of team competence
Diabetes Care Improvement Plan

Service Components
- Diabetes population focus - primary care
- Specialist focus
- Case Collaboration in priority practices
- Nurse Practice partnership
- Workforce development
- Clinical Network

☑ Survey - increased confidence
☑ Highest uptake of e-learning
☑ Reduced referrals from priority practices to specialist
☑ Ranked best DHB for HbA1c
GP referral rate to CCDHB diabetes specialist services per 100 enrolled diabetics

- **Graph 2:**

For the years 2012 to 2016:
- **Referral rate per 100:***
  - 2012: 3.0
  - 2013: 2.5
  - 2014: 3.0
  - 2015: 3.5
  - 2016 YTD: 3.0

- **Ratio priority: non-priority***
  - 2012: 120%
  - 2013: 100%
  - 2014: 80%
  - 2015: 60%
  - 2016 YTD: 40%

Legend:
- Purple: Priority practices
- Blue: Non-priority
- Black line: Ratio Priority: Non-priority
Diabetes Care Improvement Plan

- Population focus – 4 PHO’s, 15 Priority Practices
  – Numbers and ethnicity weighted

- Diabetes Practice Plans – how to change?

- Specialist Service – a more consultative role
  T1/Paeds/DM in pregnancy, complex T2, pumps, renal

- Performance Measures
  HbA$_1$C & commencing insulin in the practice
Diabetes Care Improvement Plan

- Self-Management Support
- Workforce development
- Diabetes Nurse Practice Partnership (DNPP)

August 2016

Invitation to attend
CCDHB Endocrine, Diabetes & Research Centre working with Wellington Psychological Associates (WPA)

“People with diabetes should be assessed for the presence of psychological problems with expert help provided if required”


Presented by Gerry Dowse and Vicki Breen, Psychologists

Common psychological issues for people with diabetes
- depression & anxiety
- diabetes distress
- needle phobias

When & where: Please RSVP for catering to Hope.

Email: Hope.Phillips@ccdhb.org.nz OR Ph 04 806 2140
Diabetes Nurse Practice Partnership (DNPP)

VISION Quality Diabetes Care for all

FLEXIBILITY

MDT Case conferencing

TIME

DNPP Mentoring
direct link to specialist service

TRUST

General Practice Team

COMMUNICATION

Resources

Primary Care handbook
Hypoglycaemia
Foot care

RESULTS

Specialist service
DNPP- what is it?

• Inaugural meeting February 2012 – monthly meetings
• 18 specialist diabetes nurses, varying diabetes experience from 5 services paired with practices
• Initially a degree of mistrust - “us and them”
• Heavy workloads – a challenge to find extra ½ day a week
• HR issues – fear of job losses
• Stepped approach – 15 Priority Practices

Vision - quality Diabetes Care for all
Flexibility in the how...
Organizational DCIP support

Integrated whole system approach well resourced – project lead Astuti Balram (Diplomatic++)

Agreed Aims:–

1. Reduce ethnic disparities
2. Complications – prevent & slow progression
3. Reduce the frequency of ED admissions
4. Reduce the of hospital admission rates for diabetes related complications

5. (Prevent or delay on set of diabetes) - outside remit
Delivery System Design
- A structured 2 phase approach

PHASE 1

1. Population management
2. Specialist Service
3. MDT Case Conferencing
4. Workforce Development
5. Establishment of Clinical Network
6. Performance Measures
7. Self-management Groups

PHASE 2

1. Diabetes Nurse Practice Partnership (DNPP)
Clinical Information Systems

Importance of knowing your population – using Dr info/query build – work lists

Identify sub populations
- HbA1c >80 mmol/mol (or 100) mmol/mol & on maximum orals & not using insulin Rx

Ethnicity reported – Total population with diabetes, Maori, Pacific & Asian

If you are not measuring and reviewing your work regularly it is probably not happening!!!
Decision Support A+

Building capacity & capability

- free NZNO/NZSSD e-learning package from http://www.healthmentoronline.com

- NDNKSF levels 1 & 2
Decision Support tools
Self-Management Support

Group education
6 x 2 hr course
or
Individualized sessions

On going workforce support

- Primary Care nursing Monthly Peer Supervision
  Porirua & Wgt e.g. Sick days

- MDT Case conferencing

- Education sessions

- 1:1 Mentoring

- DNPP – accreditation

National Education sessions e.g. through Pharmac- Successfully starting insulin in Primary Care

GAPS?
( Quality Standards for Diabetes Care)
- Diabetes Foot Care
- Ketone monitoring
- Pre diabetes
- Self-management
- Improving measurement & data
DNPP nursing team members
DCIP Success

• Common aims and vision
• Using a structured proven approach - Wagner’s CCM
• Importance of visionary clinical leadership (nursing & medical), Primary & Specialist
• Communication & buy–in
• Long term condition management - Team work
  – Relationships
  – Clarity of roles & responsibilities
DCIP Success

- Targeted approach - 15 Priority Practices or 6 insulin starts
- Quick wins – working in larger practices &/or those who are keen
- Resources – sharing the good ones & consistency
- NB - it is not all about hard facts
- Formal vs informal learning
- DHB to look at rolling out the model to other areas, gerontology, cardiac, renal

Success = Focus + Measurement
Remembering Rome was not build in a day!
The Future...

Synergy from working in an effective structured way with a shared vision and great team work!
Thank you for the opportunity to share our journey & some of our successes