

Manaaki Hauora-Supporting Wellness

Learning Session 3

Tuesday 10 November 2015

Collaborative Name: Addressing Diabetes Management in Manukau Locality – Primary and Secondary Care Working Together.

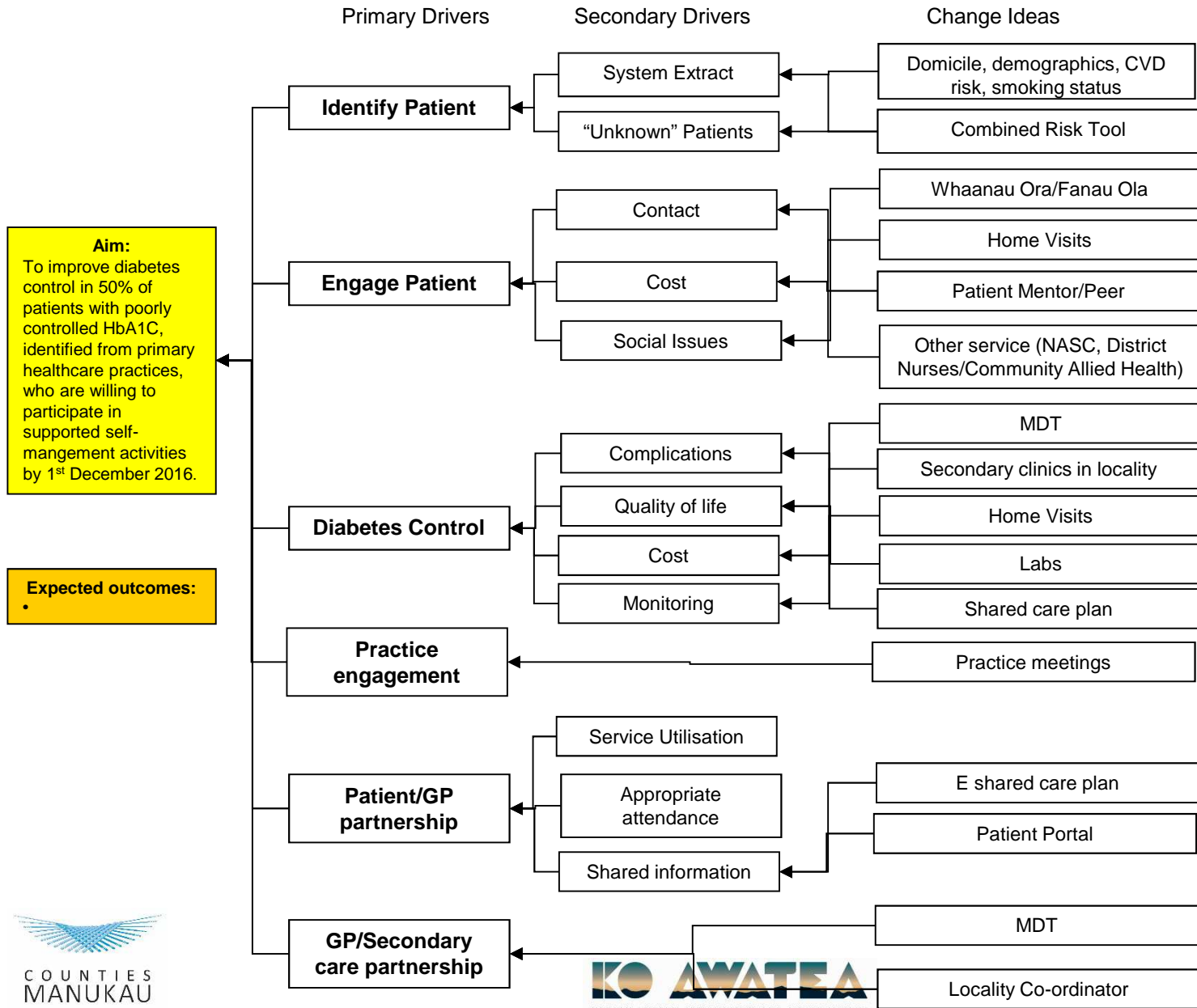


AIM

To improve diabetes control, in 50% of patients with poorly controlled HbA1c, identified from primary health care practices, who are willing to participate in supported self management activities by 1st December 2016.



Driver Diagram: Manukau Locality - Diabetes



Change Package

Secondary drivers (Theory of change)	Change concepts & change ideas tested	Evidence of Improvement
Shared information	PHO assisting with diabetes data (high HbA1c's) for each practice	This data has helped SMO's get "buy-in" and agreement to MDT's from some practices who have not had opportunity/resources to review their diabetic patients. Collecting data capture improvement in diabetes management
Practice engagement	Locality care co-ordinator has an established relationship with key contacts within the practice.	Practices more open to idea of MDT's and willing to "give it a go". 7 MDT's to date - more planned
Service Utilisation	MDT check list developed for secondary care – ensuring SMO's and locality nurses know their roles and responsibilities.	Currently being tested - Secondary care team know what their role is pre/during and post MDT to ensure efficiency and reduce variation

	Task	Responsibility	Completed
BEFORE MDT	Liaise with General Practice to arrange visit (in consultation with SMO)	Nurse	
	Obtain list of patients for review	Nurse	
	Prepare for MDT <ul style="list-style-type: none"> Pre-populate data collection spread sheet as much as possible Check with practice if laptop/concerto access available 	Nurse	
	Prepare for MDT	SMO	
DURING MDT (all visits)	Document meeting including <ul style="list-style-type: none"> Action points Who is to complete each task Update Data collection Spreadsheet 	Nurse	
	Review of notes taken	SMO	
	Copy notes and give to practice	Nurse	
	Set date for next meeting (should be within 4 – 6 weeks)	Nurse/Practice/ SMO	
	Meeting 2 onwards	If second or subsequent visit to same practice, each action points/patient reviewed at previous meeting should be revisited	Nurse/Practice/ SMO
AFTER MDT	Scan MDT Template with notes and email to SMO	Nurse	
	Dictate clinic letter to send to GP and for patient records	SMO	

Potential for Spread

Opportunities to continue this work.....YES!

- Just starting to hit the tip of the iceberg.
- Feedback from practices and PHO Practice Nurse Advisors so far has been positive
- Still need to fine tune how the MDT's are run

Opportunities to extend into other areas.....YES!

- Building on current SMO/locality nurse relationships each practice will recognise the value of holding other MDT's for complex families for example.

Achievements to Date

- 😊 Triple engagement – integration between PHO, primary and secondary care
- 😊 66 patients have been reviewed in Sept/Oct and early Nov.
- 😊 Follow up case reviews planned with 5 practices
- 😊 1 practice has completed 2 case reviews with another booked in early Jan 2016
- 😊 Case reviews have contributed to CME for 16 GP's

Most successful PDSA cycle



Practice engagement within 3 clusters of Manukau Locality has begun.



MDT format – continually refining how the MDT's are run. Learning from each cluster.



Database spreadsheet – continually refining what information to capture.

Measures Summary

- Number of patients identified with HbA1c levels greater than 65
- Number of patients discussed in MDT
- HbA1c levels of the patient
- Reach of the patient

Highlights and Lowlights

Highlights

- Enthusiasm of Primary Care about the project
- Invitation to return to a practice for follow up MDT's
- Establishing collegial relationships between primary and secondary care
- Locality project team have remained constant

Lowlights

- Time its taken to “get up and running”
- Limited resource within the locality to promote the project

Collaborative Team Members

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Expert Group:

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Working Group:

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