

Manaaki Hauora-Supporting Wellness

Learning Session 5

Tuesday 21 June 2016

Manukau Locality Diabetes Project

Clinical Lead: Carl Eagleton, Pui Ling Chan

Project Team: Pui Ling Chan, John Griffiths, Carl Eagleton, Susan Fryer,
Ashika Singh, Meg Goodman, Lynda Irvine

Project Support: Sreeraj Sasi, Rebecca Lawn



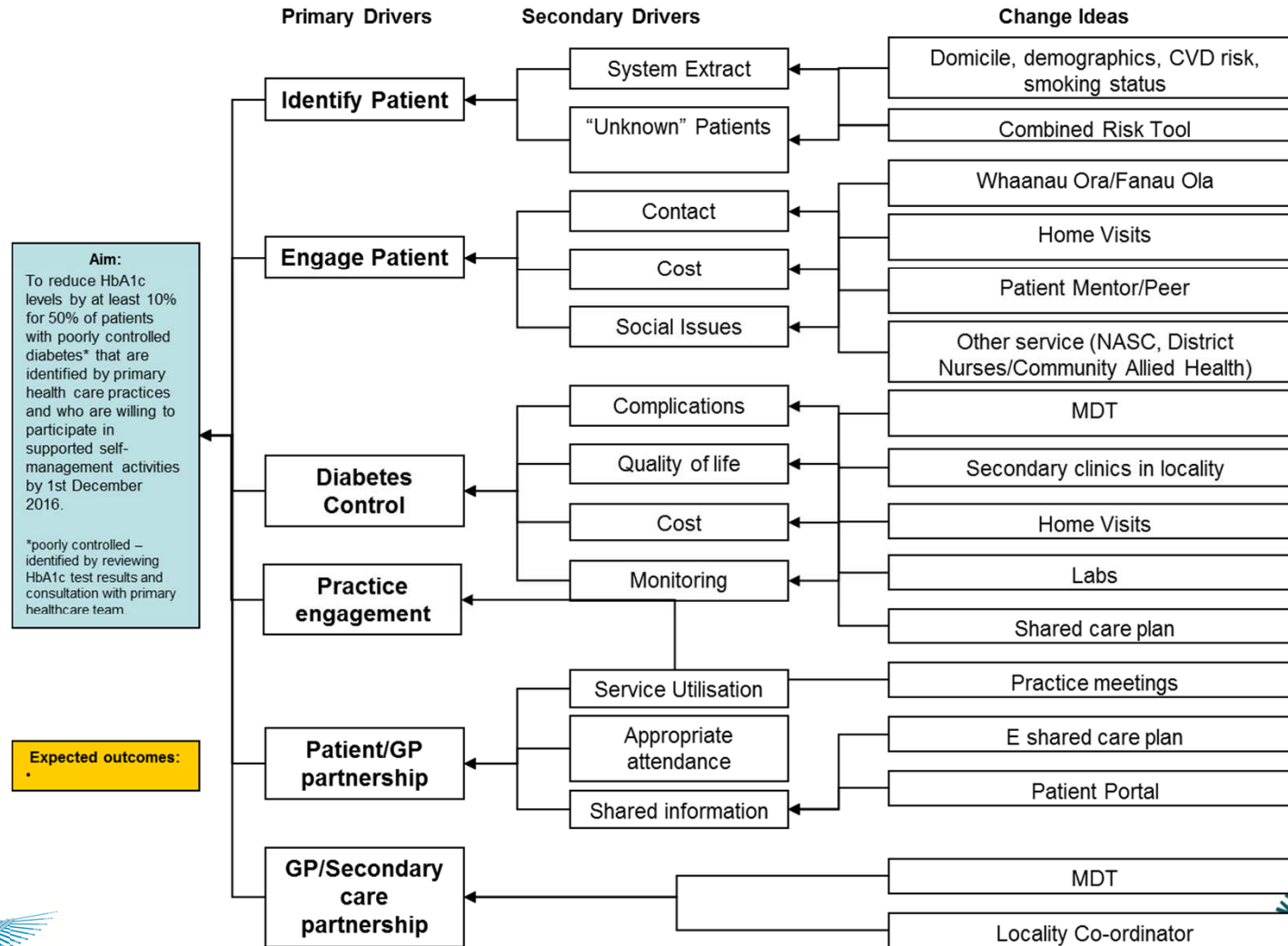
Aim

To reduce HbA1c levels by at least 10% for 50% of patients with poorly controlled diabetes* that are identified by primary health care practices and who are willing to participate in supported self-management activities by 1st December 2016.

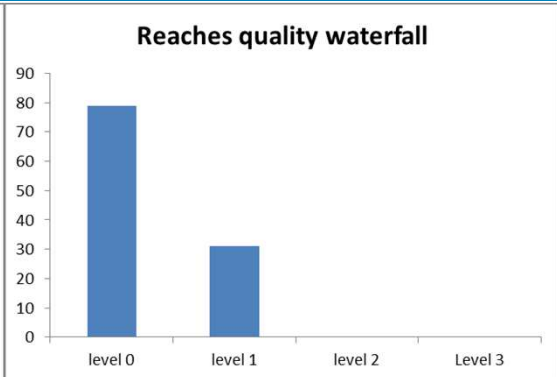
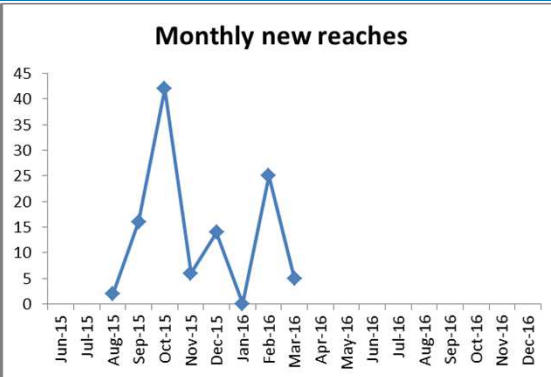
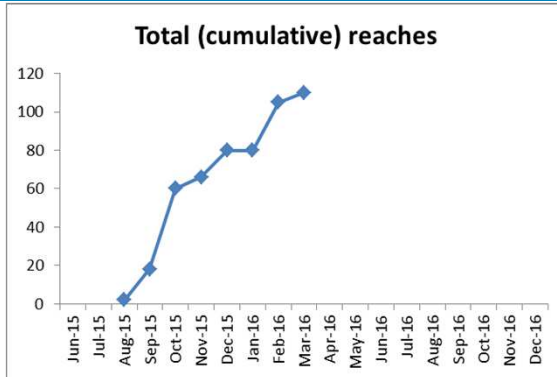
*poorly controlled – identified by reviewing HbA1c test results and consultation with primary healthcare team.

Driver Diagram

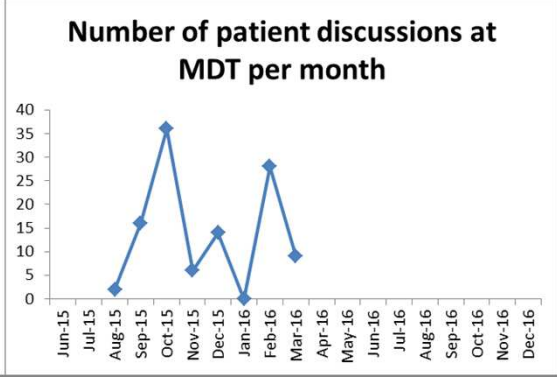
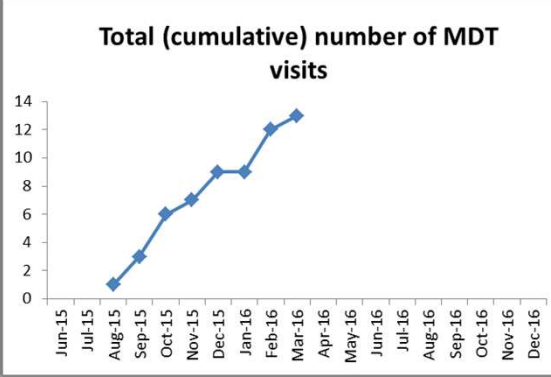
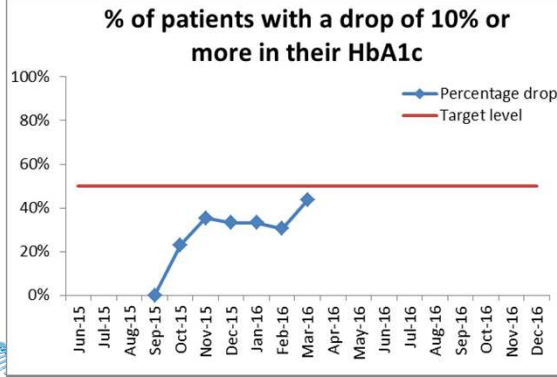
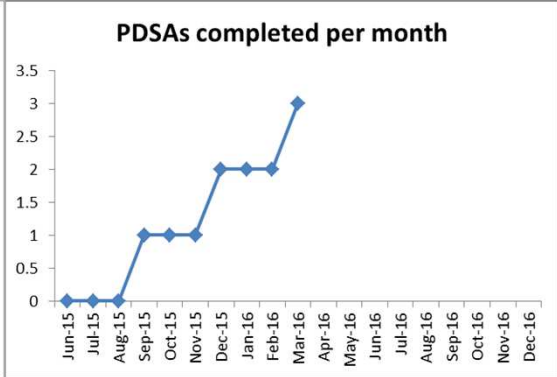
Driver Diagram: Manukau Locality - Diabetes



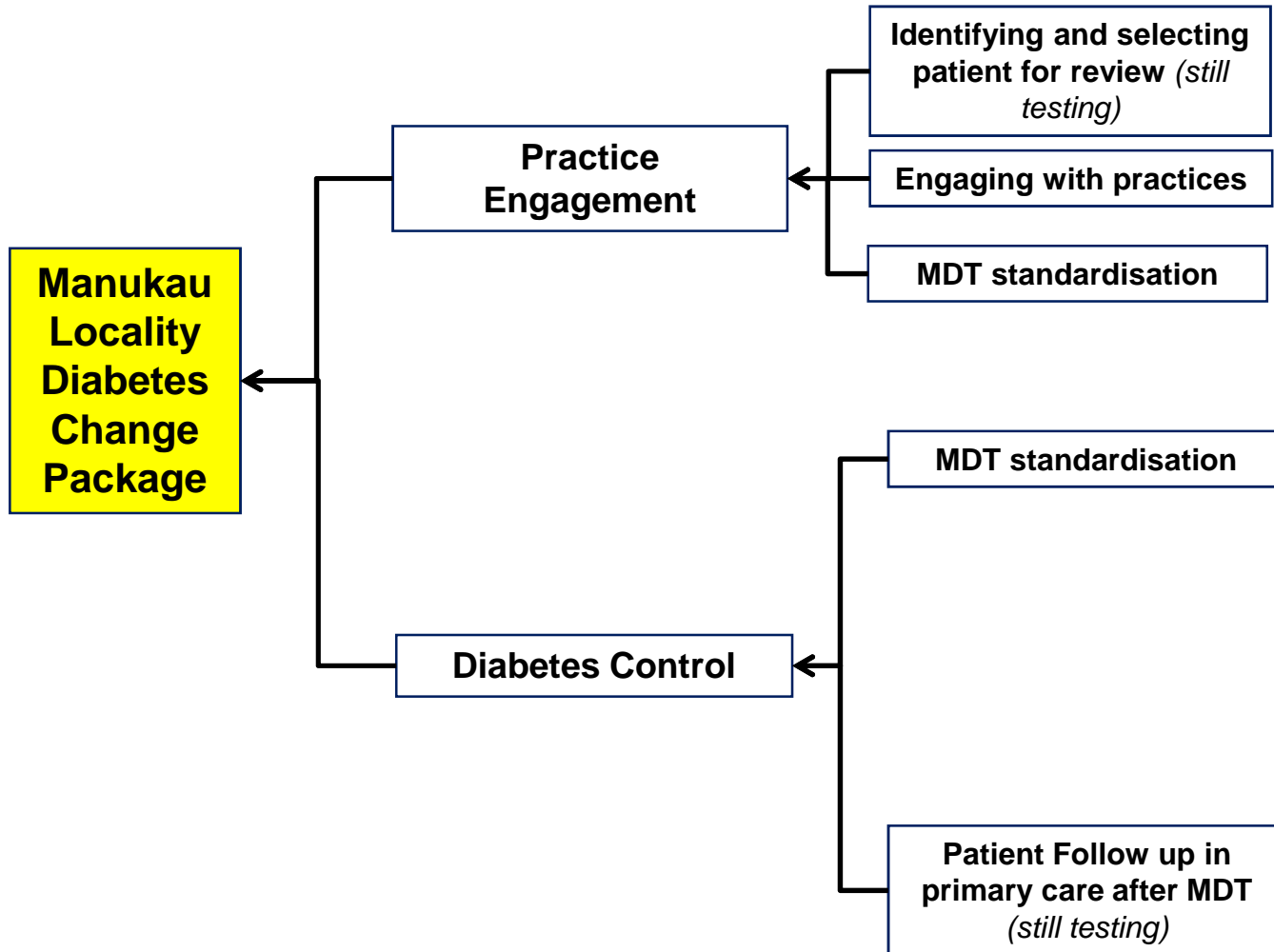
Dashboard



**Manaaki Hauora
ML-Diabetes
March 2016**



Change Package



Ask and Offer

Ask: Our 2 greatest unresolved challenges are:

- Negotiating (extra) time with each practice to review previous MDT cases – how can we prove that getting an update on former MDT patients is equally as important as discussing new cases?
- Getting ALL the project group in the same room at the same time.

Offer: The 2 greatest challenges we have resolved/making progress are:

- Seeing the MDT process through the eyes of new members: making more efficient use of e-shared care during MDT's.
- On line surveys did not yield any responses to our request for practice feedback. Much improved response rate when locality nurse visited each practice with hard copies and collected the following week.

Patient and Whaanau Story

Patient & Whaanau Story: Highlighting ways in which the Locality SMO and Locality nurse provide support to patients and primary care teams.

- **26/05** – Introductory visit to a medical centre (high enrolment) in Manurewa cluster. The team identify a 48yrs old female patient (T1DM) who “is not engaged with the practice”; DNA’s; complex social situation. HbA1C 109 in Oct 2015
- Locality SMO offers to review patient the following week in the medical centre IF she agrees to attend an appointment.
- **28/05** – Locality nurse does “cold call” to patients’ home explaining her role with the medical centre. Patient receives written information about the MDT; an offer of transport (ARI funding) and a blood form to be completed prior to appointment.

Patient & Whaanau Story

- **30/05** – Practice nurse follows up with ph/call to patient. Agrees to appointment
- **01/06** – HbA1c 111
- **02/06** – Transport arranged to bring patient to medical centre. Reviewed by Locality SMO. Very unwell on arrival.

Inclusive approach; supporting the practice and patient; reminding colleagues on the varying use of ARI funding.

Achievements to Date

- To date 44% have had an improvement $\geq 10\%$ in their HbA1c and the average improvement in HbA1c is 11.4 mmol/mol with a range of +26.0 to -72 mmol/mol (April 2016)
- Triple engagement – integration between PHO, primary and secondary care
- Enthusiasm of Primary Care about the project
- Sharing knowledge and expertise – promoting the project at conferences.