PPC CARE BUNDLE

Diabetes – Opportunistic Screening

Aim

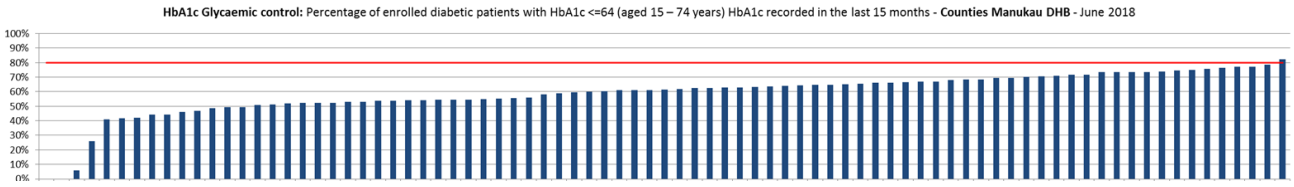
To optimise treatment and educate diabetic patients every time they are seen in primary care

Background

Diabetes is a complex disease that has both health and social drivers. There are approximately 37,000 people with diabetes enrolled with general practices in Counties. Of those, more than 8,500 have been identified as poorly controlled with an HbA1c > 74.9 mmol/mol. This number has increased slightly over the past 5 years.

97% of people with poorly controlled diabetes attend their primary care practice within a year; therefore targeting these patients opportunistically provides an opportunity to improve their care.

The below graph shows the percentage of enrolled diabetic patients with a HbA1c under 65 for each individual practice domiciled in Counties Manukau. The target is set at 80%; therefore, this reflects a significant opportunity to improve outcomes for the diabetic population.



Instructions

1. Select all diabetic patients who presented to clinic in the last month. Change this time frame each time you run a query. A query is currently being developed for MedTech and My Practice PMSs to assist with this
2. From the identified list, randomly select a sample of 10 patients
3. Print and complete the Paper Form (included in this spreadsheet)

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4. Transfer the data collected to the Data Collection Form in this spreadsheet. Please make sure the date is entered beside each individual record. The data will automatically be collated and displayed on the run charts, which can be printed as needed

5. Save the spreadsheet. Email the completed spreadsheet by or on the 10th of each month (i.e. June data is due on 10 July, July data is due on 10 August). The spreadsheet is to be emailed to your PHO facilitator.

Audit Questions

Measures	Rationale
Was a weight taken and discussed if overweight or obese?	• There is debate over whether diabetic patients can ever be described as being "in remission" however substantial sustained weight loss can normalise the HbA1c and prevent the complications of diabetes[i]. • The Ministry of Health guidelines for weight management in adults in New Zealand recommend yearly weight and BMI measurement for those in the healthy weight range and more frequent measurement and discussion on food and activity for those who are overweight, and a discussion on current and long term health risks for all those who are in the obese range.[ii]
Was the blood pressure taken?	• There is a clear link between type 2 diabetes and high blood pressure (hypertension) and / or disordered levels of fats (cholesterol) in the blood [iii] • People with diabetes should be offered blood pressure, blood lipid and anti-platelet therapy to lower cardiovascular risk when required in accordance with current recommendations. [iv]
Was a blood form given if the patient had not had an HbA1c in the last 12 months for a well-controlled patient (HbA1c < 65) or in the last 3 months if the previous HbA1c was >65?	• HbA1c remains the preferred and only really useful, test for monitoring glycaemic control in people with diabetes, in primary care. [v] • In patients with an initial HbA1c of >7%, testing every three months was associated with better glycemic control.[vi]
Was diabetes discussed during the consultation and a plan documented in the notes to adjust the care if necessary?	• Management of type 2 diabetes requires regular review and timely intensification of treatment, including insulin initiation if appropriate [vii]
Overall compliance	

Theory of Improvement

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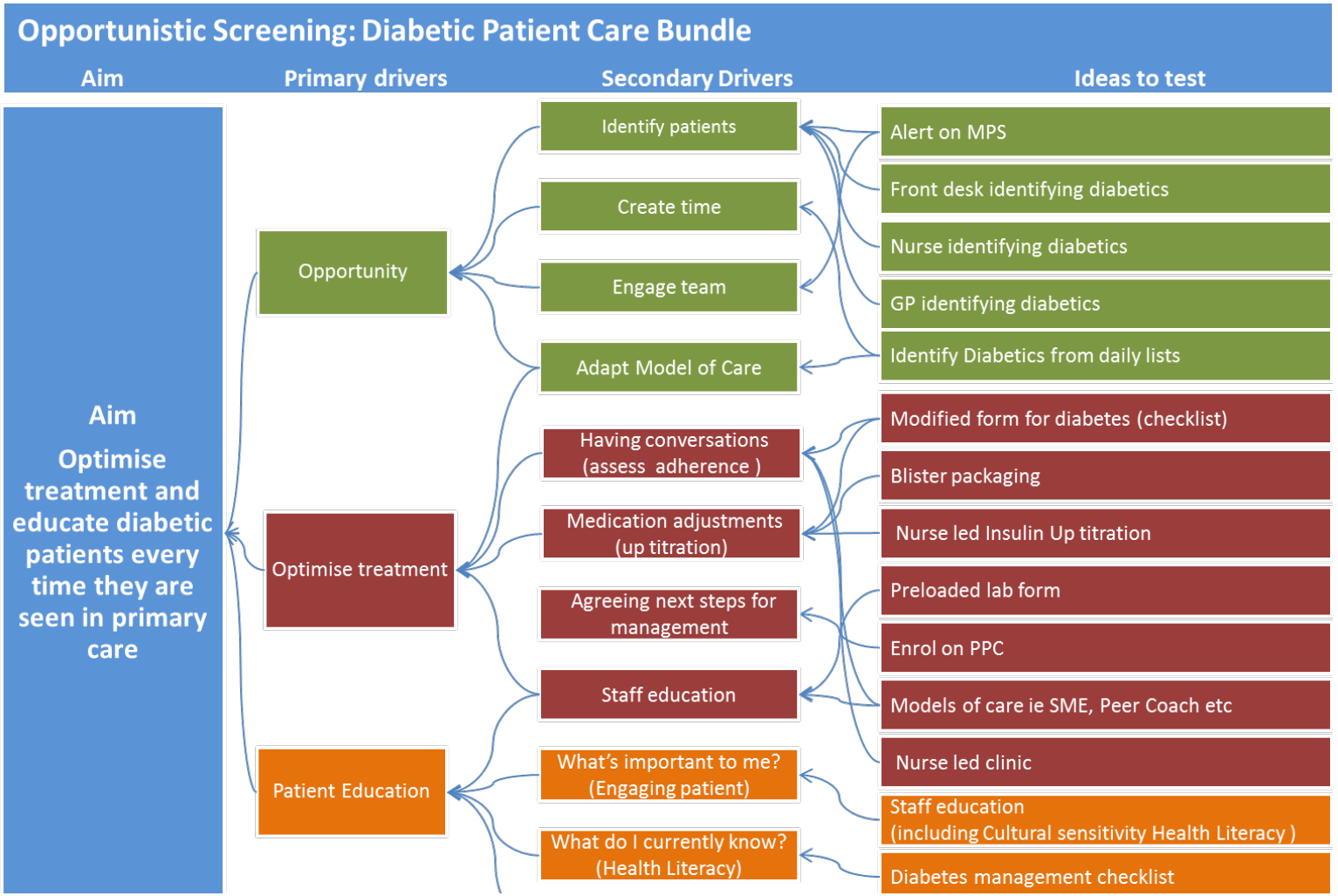

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Change Ideas Tested by Previous Practices

General	• Having a practice champion who will lead this work and maintain the enthusiasm of the staff • Blister packaging • Models of care reviewed • Enrol patients on PPC if there are interventions that could benefit them
Practice Processes	• Diabetes management checklist • Developing an insulin start "package" • Medication review • GP identifying diabetics at each consultation and ensuring their management is optimised
Recording process in patient management system	• Preloaded lab form so one click brings up all the required investigations • Placing alerts on PMS • Modified form for diabetes on the PMS to make it easier not to forget something in the consultation • Recalls generated for diabetics who are poorly controlled
Practice team roles and responsibilities	• Nurse led clinic • Front desk maintaining current contact details • Staff education including cultural competency and health literacy • Nurse identifying diabetics at Triage and starting conversations about diabetes • Staff education to feel more comfortable discussing diabetes with patients and to escalate management when required. Also training in insulin starts and up titration.
Patient education	• Information leaflets to patients

Outcome Measures

- Was a weight taken and discussed if overweight or obese?
- Was the blood pressure taken?
- Was a blood form given if the patient had not had an HbA1c in the last 12 months for a well-controlled patient (HbA1c < 65) or in the last 3 months if the previous HbA1c was >65?
- Was diabetes discussed during the consultation and a plan documented in the notes to adjust the care if necessary?

Addendum

Although not part of this bundle the practice may choose to do a query build every 3-6 months to monitor the overall effect of their interventions.

- Is there an overall improvement in HbA1c?
- Are there fewer patients in the practice in the poorly controlled range of HbA1c

Additional Resources

Diabetes Self-Management Education (DSME) Best Practice Manual

Module 1 Living with the diagnosis of diabetes – Content 1.0

e.g. A diabetes problem each encounters

1.1 - Empowerment model & Self-management Concept

Key points

- Traditionally the role of the 'patient' has been passive
- This response is not effective in treating conditions such as Diabetes.
- Diabetes is an example of a long term condition, one that does not go away or is not cured.
- As a result it is important to work collaboratively with the individual and their family to help them to manage their condition on their own with support.
- The reality of diabetes is that most of the care is provided by the person who has the condition.

Participant Handouts

- Staying well with Type 2 Diabetes (Diabetes NZ)
- Group discussion/chart

Questions to facilitate discussion

- What questions/concerns do you want to address today?
- What is important for you to

- The main role of health care professionals is to provide ongoing expertise, education and support so the person with diabetes can make informed decisions on a daily basis.
- Positive self-management of diabetes is most likely when people with diabetes are able to make informed choices and decisions that will achieve their personal goals.

know by the end of today's session?
- What is the hardest thing for you right now in managing your diabetes?
- How is caring for diabetes different from caring for the flu or a skin infection?

1.2 - Feelings about living with the diagnosis of having diabetes

Key points

- Nobody wants to have diabetes but it is an opportunity to take stock and take control.
- Type 2 Diabetes is an inherited condition- it is therefore not the participant's fault that they got diabetes.
- Everyone with diabetes experiences a variety of thoughts or feelings upon hearing the diagnosis of diabetes. Some of these will be directly related to their knowledge and beliefs about the cause of diabetes, which may not necessarily be accurate or complete.
- Initial reactions to diabetes include denial, disbelief, fear, anger, and why me? These reactions can be based on misinformation or a lack of information.
- Feelings change from day to day, or even within the same day. It is important to be aware of feelings and this can affect our ability to care for ourselves.
- The key to learning a healthy way of living with diabetes is to learn how to manage your diabetes = self-management. As our thoughts influence our actions and one of the first tasks is to accept that most of the care of diabetes is in your own hands.
- Self-management must be learned and practiced. You will need to learn all you can about diabetes and as you learn you will find that there are changes especially lifestyle changes, to be made to improve your health. This is in addition to choices made on a daily basis.

Participant Handouts

- Staying well with Type 2 Diabetes (Diabetes NZ)

Questions to facilitate discussion

- What were your thoughts when you were told you had diabetes?
- What has your doctor or nurse told you about diabetes?
- What does having diabetes mean to you?
- How have you coped with situations in the past?'
- What have you found works for you?
- Who do you find is the most helpful to talk to when you are upset?
- Why do you think you have developed Type 2 diabetes?
- What do you think you need

- It is important to learn about the disease process as well as learning new skills to positively manage diabetes. These skills should be practiced so they become habits.
- • This behaviour change is a step-wise process and doesn't require everything to be changed at once.

to help you live well with diabetes?

- What are the choices that you make on a daily basis that affect your blood glucose levels?

Sources

Updated 18/10/2018

i McCombie Louise, Leslie Wilma, Taylor Roy, Kennon Brian, Sattar Naveed, Lean Mike E J et al. Beating type 2 diabetes into remission BMJ 2017; 358 :j4030

ii Ministry of Health. 2017. Clinical Guidelines for Weight Management in New Zealand Adults. Wellington: Ministry of Health.

iii Diabetes New Zealand, *Understanding Type Two Diabetes*. https://www.diabetes.org.nz/understand-type-2-diabetes/

iv Ministry of Health. 2014. Quality Standards for Diabetes Care Toolkit. Wellington: Ministry of Health.

v BPAC 2012 BPJ: The new role of HbA1c in diagnosing type 2 diabetes

vi Driskell OJ, Holland D, Waldron JL, Ford C, Scargill JJ et al. Reduced Testing Frequency for Glycated Hemoglobin, HbA1c, is Associated with Deteriorating Diabetes Control. Diabetes Care. 2014 October.

vii BPac,2015, Managing patients with type 2 diabetes: from lifestyle to insulin. https://bpac.org.nz/BPJ/2015/December/docs/BPJ72-diabetes.pdf