PPC CARE BUNDLE

Diabetes – Targeting Care

Aim

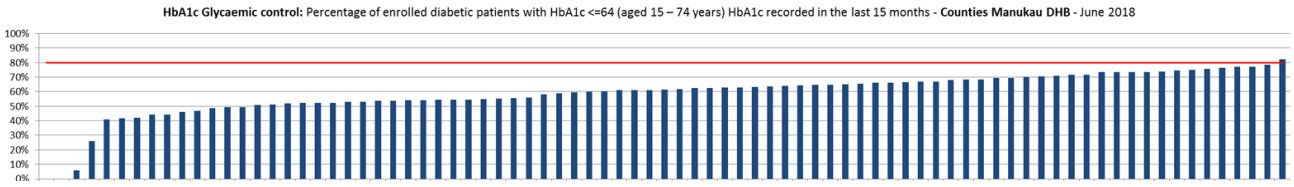
To effectively recall and intensify care of patients with suboptimal control of their diabetes

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.



The goals of treatment for type 2 diabetes are to prevent or delay complications and maintain quality of life. This requires control of glycaemia and cardiovascular risk factor management, regular follow-up, and, importantly, a patient-centred approach to enhance patient engagement in self-care activities. [i]

Equity

- Pacific peoples develop diabetes earlier and experience more complications than New Zealand Europeans with the condition (Ministry of Health 2014a).

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- Adults living in the most socioeconomically deprived areas are over three times more likely to report that they have been diagnosed with diabetes than adults living in the least deprived areas (Ministry of Health 2014f).
- People with a history of long-term mental illness have significantly higher rates of diabetes (Te Pou 2014).

Instructions

1. Identify diabetic patients with suboptimal control (matching the level you have agreed to work on) by doing a query build through the PMS. Suboptimal control will be defined by the practice, dependent on their patient population. This level may also change with time as the practice progresses with the audit:
    - HbA1C >100;
    - HbA1C >80; or
    - HbA1C >65
2. From the identified list, randomly select a sample of 10 patients
3. Print and complete the Paper Form (included in this spreadsheet)
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 recall has been generated and actioned at least 3 times if necessary	• Recalls are used when it is paramount for a patient to attend a clinic, usually when there is an abnormal test result. Recalls must be followed through until the patient attends an appointment with the doctor and the consultation is then documented in the patient's notes. [ii] • Good communication is essential for the provision of high quality medical care and key to supporting patients' informed decision-making. Doctors should facilitate patients' informed health care decisions by providing relevant information regarding the risks and benefits of attending (or not attending) a recommended test, referral, follow-up appointment, or recall appointment.[iii]

	• A doctor should, however, make a reasonable attempt to inform a patient who has a clinically significant result or diagnosis but has not attended a follow-up appointment. In determining what steps should be taken to contact a patient, the following should be considered: [iv] ○ the seriousness of the patient's medical condition; ○ the associated risk to the patient of not receiving or delaying treatment; ○ the significance or abnormality of any tests or reports
Was a medication review completed and medication optimised?	• Management of type 2 diabetes requires regular review and timely intensification of treatment, including insulin initiation [v] • Despite clinical practice guidelines that recommend frequent monitoring of HbA1c (every 3 months) and aggressive escalation of antihyperglycemic therapies, the intensification of therapy in patients with uncontrolled type 2 diabetes (T2D) is often inappropriately delayed. The failure of clinicians to intensify therapy when clinically indicated has been termed "clinical inertia." Most alarming was the finding that even among patients in the highest index HbA1c category (≥9% [≥75 mmol/mol]), therapy was not intensified in 44% of patients, and slightly more than half (53%) of those with an HbA1c between 8 and 8.9% (64 and 74 mmol/mol) did not have their therapy intensified. [vi]
Was blister packaging discussed?	• 8-month randomized controlled double-blind study among diabetic patients with poor glucose control (HbA1c >9.0%) in an urban area of South Auckland, New Zealand… found HbA1c was reduced by 0.95+/-0.22% in the calendar blister pack group [vii]
If the clinical target is not achieved at least one new model of care is considered at each consultation: • Self-management education • Peer Coach • Clinical psychologist • Green prescription • Dietitian • MDT meeting	• There is good evidence that self-management education and support, as part of a comprehensive wellness plan, can improve clinical outcomes and quality of life. Programmes are particularly effective when they incorporate behavioural and psychological strategies, and are age and culturally appropriate [viii] • Participants who were engaged in the **life coach program** were 40% less likely to experience poor control of their A1c, 50% more likely to meet the ADA A1c goal of <7% [ix] • Integrative health coaching was found to decrease perceived barriers to medication adherence, and increase patient activation, perceived social support and benefit. Improvements in the coaching group alone were also observed for self-reported adherence, exercise frequency, stress, and perceived health status. Coaching participants with elevated baseline HbA1C (>/=7%) significantly reduced their HbA1C [x] • The Green Prescription primary care intervention is effective over the longer term (2–3 years) for men and women. Compliance in Green Prescription could be improved with more

	communication and collaboration between service providers. [xi] • Nurse practitioner /Community health worker group had significantly greater 12-month improvement in total cholesterol (difference, 19.7 mg/dL), LDL cholesterol (difference,15.9 mg/dL), triglycerides (difference, 16.3 mg/dL), systolic blood pressure (difference, 6.2 mm Hg), diastolic blood pressure (difference, 3.1 mm Hg), HbA1c (difference, 0.5%), and perceptions of the quality of their chronic illness care. [xii] • An integrated model of care using community health-care workers improved BP control in difficult to manage patients with chronic diabetic kidney disease compared with conventional care. [xiii]
Overall compliance	

Theory of Improvement

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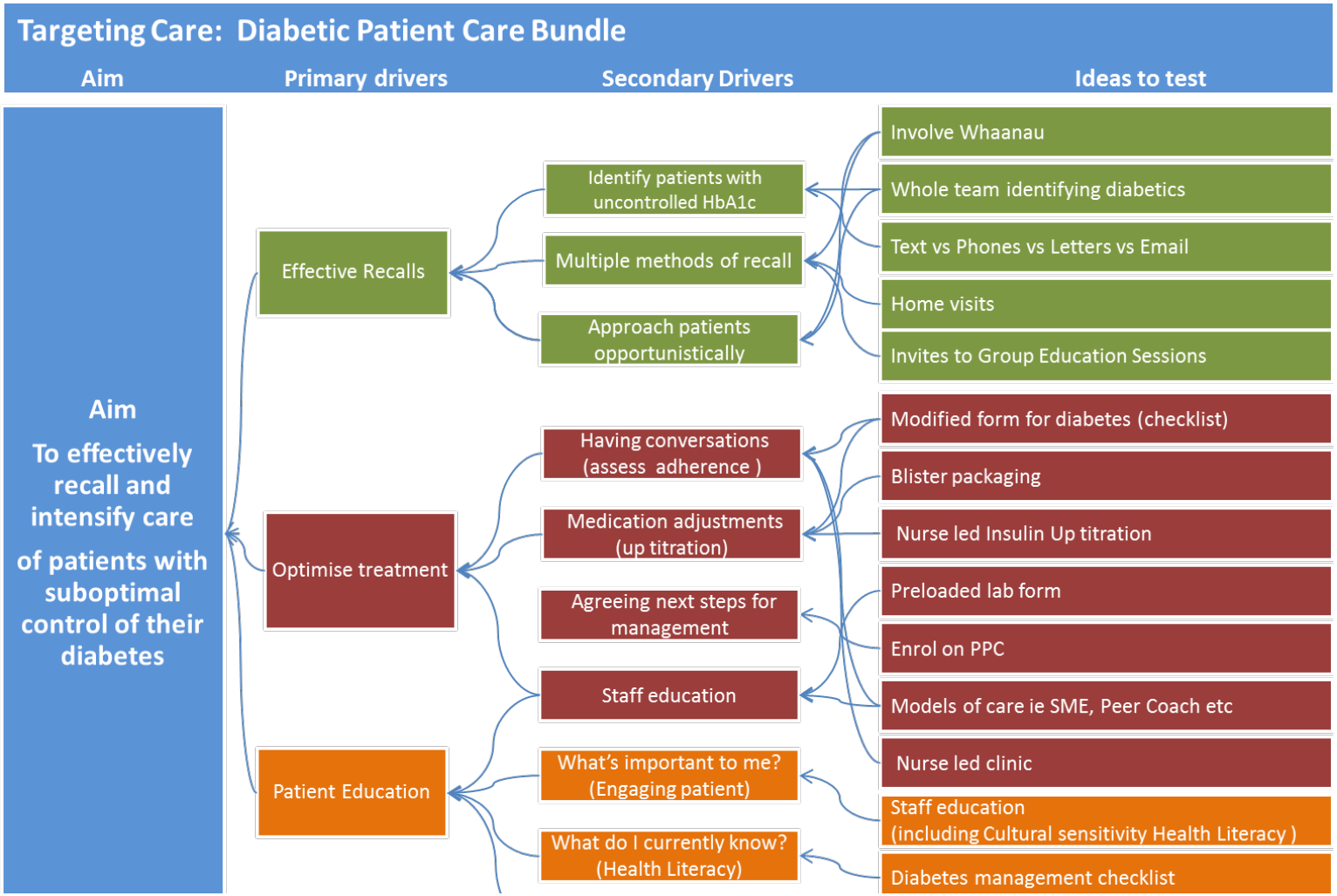

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Change Ideas Tested by Previous Practices

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 • Involving family and whaanau
Practice Processes	• Diabetes management checklist • Developing an insulin start "package" • Medication review • GP identifying diabetics at each consultation and ensuring their management is optimised • Recalls using multiple modalities, e.g. text, phone, letters, and email • Home visits to patients • Invites to group education sessions
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 and identifying diabetics on arrival to practice • 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

- Recall generated and actioned at least 3 times if necessary
- Medication review completed and medication optimised
- Blister packaging discussed
- One new model of care is considered at each consultation if the clinical target has not been achieved

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.
- 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.

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 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.
- 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.

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 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

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iii Australian Medical Association: Patient Follow-Up, Recall and Reminder Systems – 2013 https://ama.com.au/position-statement/patient-follow-recall-and-reminder-systems-2013

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x Wolever RQ1, Dreusicke M1, Fikkan J1, Hawkins TV1, Yeung S1, Wakefield J1, Duda L1, Flowers P2, Cook C2, Skinner E2 Integrative health coaching for patients with type 2 diabetes: a randomized clinical trial.Diabetes Educ. 2010 Jul-Aug;36(4):629-39. doi: 10.1177/0145721710371523. Epub 2010 Jun 9.

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xiii Cheri Hotu, Warwick Bagg, John Collins, Lorraine Harwood, Gillian Whalley, Robert Doughty, Greg Gamble, Geoffrey Braatvedt, on behalf of the DEFEND investigators; *A community-based model of care improves blood pressure control and delays progression of proteinuria, left ventricular hypertrophy and diastolic dysfunction in Māori and Pacific patients with type 2 diabetes and chronic kidney disease: a randomized controlled trial*, Nephrology Dialysis Transplantation, Volume 25, Issue 10, 1 October 2010, Pages 3260–3266, https://doi.org/10.1093/ndt/gfq168