Living well with diabetes in Linwood

Primary Care Improvement project

March 2018

Health Quality & Safety Commission New Zealand
Kaipū Tauranga Hauora o Aotearoa

Ko Awatea
Health System Innovation and Improvement

Background/Context

- Linwood Medical Centre is a practice with over 10,000 patients, consisting of four practices that having recently merged in the last 18 months. Located in the Linwood district of Christchurch, we have an enrolled patient population with a higher percentage of Maori, Pacific patients as compared to the greater Canterbury area.

Ethnicity of patients coded with diabetes in general practice						
	Diabetes Population	Other	Maori	Pacific	Indian	Asian
Linwood Medical Centre	662	69.2%	13.9%	10.7%	3.5%	2.7%
Pegasus PHO	16,853	78.3%	7.6%	4.7%	2.5%	7.0%
Canterbury DHB	20,824	79.2%	7.3%	4.4%	2.5%	6.7%

Improvement Team

- **Linwood Medical Centre** Jane Heatherington CD
- Zach Muhrer, GM, Lisa Yetton, RN, Lili Toma RN, MaryJane RN
- Helena Duff, Social Worker
- **Pegasus PHO** - Karen O'Malley, Practice Support Liaison
- Maureen Van Venrooy, PCW
- **Linwood Dispensary** - Kezia Buttle, Pharmacist
- **CDHB** - Juliet Berkeley, Diabetes & Endocrinology CD
- Sandy Marshall, Diabetes Centre CNM
- Sharon Walsh, CNS, Prescriber
- Debbie Rawiri Maori CNS, Lupe Tuulua Pacific CNS prescriber
- Steve Percival, Podiatrist, Danielle Lingard Dietitian
- **Nurse Maude** – Saskia Rietveld Community Diabetes CNS, Hayley Maxwell Dietician

Project

- The practice diabetes population is 662 of this 60 have HBA1c >90 who have been referred but have not attended the specialist centre or discontinued their care. This group continue to require further specialist input.
- This group has a HbA1c average of 106mmol/mol
- 30% of diabetes patients with a retinal screening recording Q2 2017/18

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Linwood medical centre

Pegasus™

Whakakotahi
Primary care quality improvement challenge 2018
Find out more at www.hqsc.govt.nz/whakakotahi-2018

Linwood DISPENSARY

Nurse Maude
Caring for the people of Canterbury since 1896

Problem Statement

- LMC diabetes patients with elevated HbA1c ranges and apparent low retinal screening uptake.
- A partnership model is formed providing a collaboration of health professionals working alongside consumers with an aim of narrowing the equity gap, improving diabetes outcomes for LMC patients.
- The partnership team is to establish key targeted actions than can be tested, modified and implemented if identified changes result in a quality improvement.
- Co-design of services with consumers, primary teams and specialist services.

Aim Statement

- To improve 2 key outcomes for Linwood medical centre diabetes patients by 10%. These outcomes will be retinal screening and HbA1c between March 2018 and 2019.

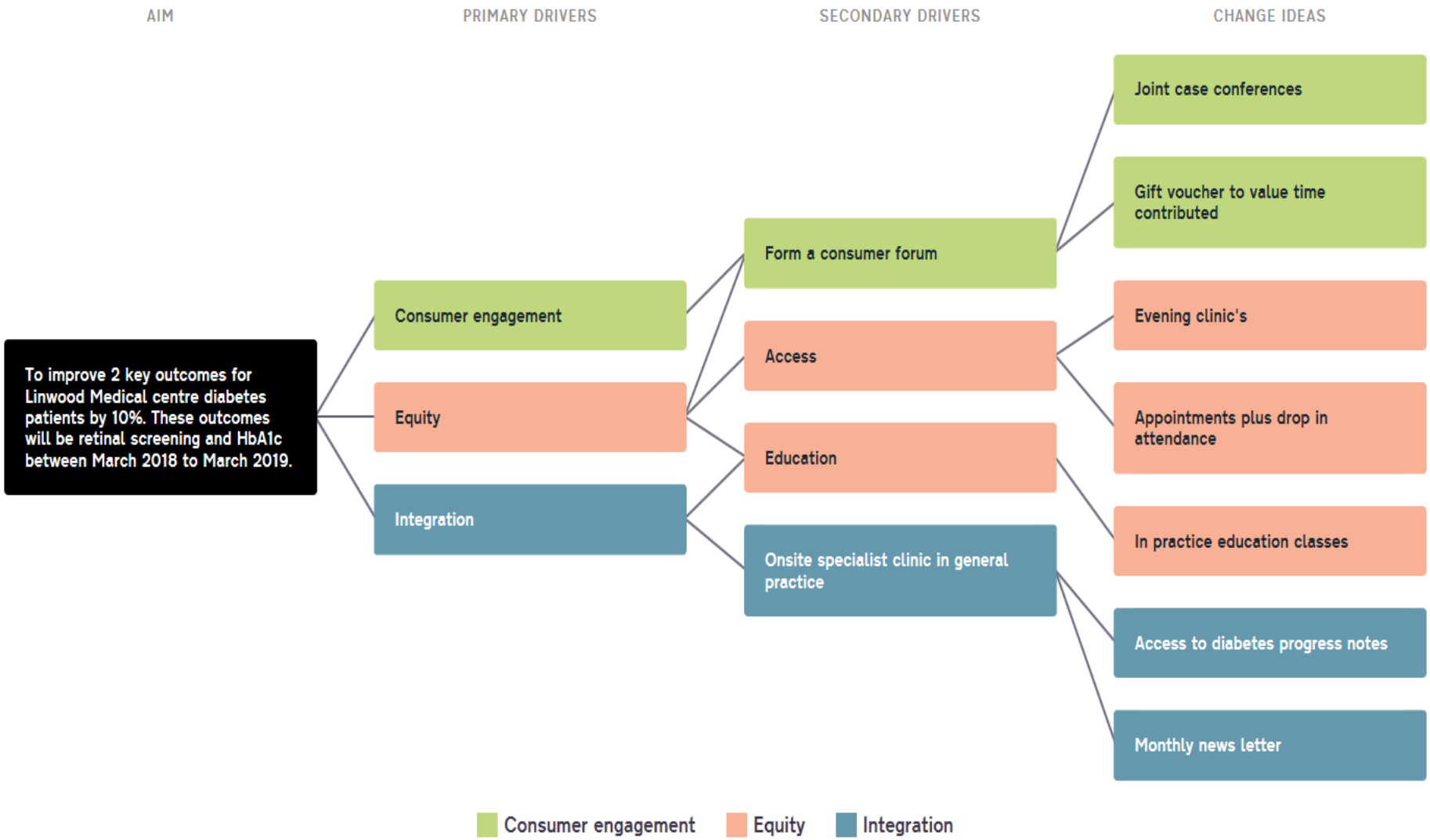
- The principle aims of the Living well with diabetes in Linwood are consumer engagement, equity and Integration.

- These are represented as with the NZ triple Aim – Population, Individual and system.

  Improved health and equity for all populations

  Improved quality, safety & experience of care

  Best value for public health system resources


AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE IDEAS
To improve 2 key outcomes for Linwood Medical centre diabetes patients by 10%. These outcomes will be retinal screening and HbA1c between March 2018 to March 2019.
Consumer engagement
Equity
Integration
Form a consumer forum
Access
Education
Onsite specialist clinic in general practice
Joint case conferences
Gift voucher to value time contributed
Evening clinic's
Appointments plus drop in attendance
In practice education classes
Access to diabetes progress notes
Monthly news letter
Consumer engagement
Equity
Integration

Diagnose the problem – data

- HbA1c – Practice level data indicates a collective of patients who have not accessed specialist level care via previous referrals – who's diabetes status remains poor.

- There are real barriers to accessing specialist level care, as parking, hours of clinic during work related commitment, health literacy.

Diagnose the problem- tools

- Our team came together for a workshop supported by members from the HQSC on the 12 March.

- The use of post-it notes, flipchart paper with a Ishikawa diagram or fishbone diagram. Using the labels - staff, processes, training, patients, environment and equipment - theme's began to emerge.

Capturing the Patient Experience

- Consumer group formation is underway
- The group is partial formed of 3 members of the larger local Diabetes Consumer group.
- The local is well established, operating at high integrated levels diabetes governance.
- The experience and familiarity of these key members will strengthen the LMC consumer group formation.

- The LMC consumer group will guide and advise our teams significantly;

  Preference for particular times of clinic?

  Preferred day of the week?

  Planned or drop in appointment options, or combination?

  What elements of the patients diabetes care worries them the most?

Stakeholders & Communication

- To elevate voices of all members from the partnership group as listed below but not limited to – suggestions from the group will influence and extend opportunities.
- Monthly team updates – email to wider stakeholder group.
- Communication board for members to jot notes, inquiries and ideas to be included in the monthly update.
- Mirror story boards centrally located at LMC plus the Diabetes centre – to be actioned.
- Access to shared progress notes for HP's – technical IT challenges to be resolved.

Highlights/lowlights

Highlights

- Collaboration with committed team members. Willingness from those with invested interest external to the clinical team I.E Sport Canterbury, Eye department.
- Sport Canterbury commitment to provide a Diabetes Be-Active program

- Notable improvement to date with one Key measure – Retinal Screening positive improvement from 30% to 37%. Likely due to direct impact of GP's having heightened awareness, diabetes project.
- Introduction of a new screening location – found favourable to patients.

Lowlights

- Pressure to deliver – gradual coming together of the consumer group.

Key Success/barriers

- There is good support and buy in for the project.

- Time invested into a appreciative inquiry into retinal screening status.

  Identification of urgent care required by Eye Department, plus systems gaps in data storage.

- Notable improvement to date with one Key measure – Retinal Screening positive improvement from 30% to 37% Q3 2017/18.
- Likely due to direct impact of GP's having heightened awareness, diabetes project.
- Direct cause impact also likely with increased access to new facilities.

Lessons Learned

- Patience – the need for consumer level information remains a gap.

Dashboard of Measurements

- Outcome Measure/s
  - Improved LMC practice HbA1c for those >64mmol/mol
  - Improve on patient group HbA1c who attend Diabetes Clinic.

- Process Measures
  - Coordinated care, primary, specialist and pharmacy teams. 5 clinics
  - Diabetes Be-Active program. Winter module / Summer module?
  - Consumer satisfaction

- Balancing Measures
  - Attendance to diabetes clinic
  - Consumer satisfaction
  - General practice increased diabetes specific knowledge and confidence

Balance of measures for improvement: HbA1c

	Description	Measure	Current performance	Target performance
Outcome Measure	Improve HbA1c in patients >64mmol/mol	HbA1c	TBA ? Zach	<10%
Process Measure	Increase referral to Diabetes Be-Active program	PA referral to program	180pa	300pa
Balance Measure	Patients booked for integrated clinic	Engagement episodes increase.	?DNA	Engagement +

Change Ideas to Test

- Co-design, collaboration with Sport Canterbury in producing a specific diabetes Be-Active program.
- In practice Green prescription consultation held at the practice.
- Appreciative inquiry in determining accuracy of LMC retinal screen status.
- Formation of a consumer group
- Integrated diabetes clinic's
- Diabetes shared documentation access

Diabetes specific Be-Active program
Pre-diabetes / Type two introduction

- **Plan**

  Provision of a specific Diabetes Be-Active program

  Co-designed Diabetes Be-Active program material with specialist team and Sport Canterbury.

- **Do**

  October 8 week program. Pre-program wellness questionnaire completed.

  Specialist community dietician / Nurse to deliver Diabetes specific clinical content

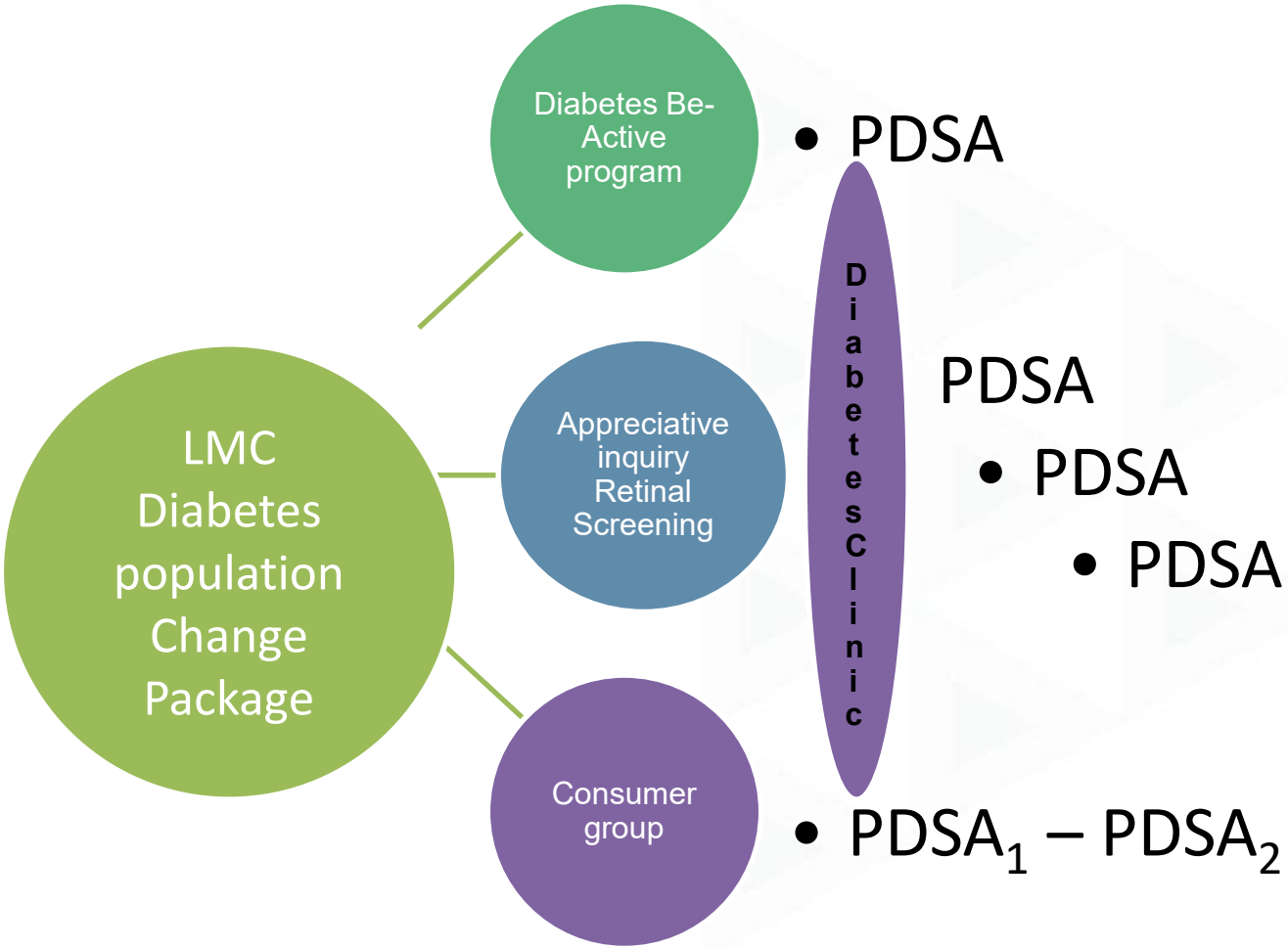
- **Study**

  Pre – post measures – HbA1c, BP, BMI, patient wellness scale.

- **Act**

  Discussion to be evolved, outcome dependant – Chronic conditions Be-Active program.

Diabetes Integrated team Clinic



Data Analysis & Reporting

- Design a run chart, monthly measures for hbA1c / Retinal screening practice group, plus clinical cohort.

- Regular sharing updates, platform for shared thoughts