**Quality improvement scientific symposium virtual session one: Rapid-fire presentation – Pauline Ansley**

**Accessible transcript**

**Visual**

**On a black screen next to a PowerPoint presentation slide is a small video feed; in it, Pauline Ansley, a bespectacled woman with short, dark hair. The woman sits in front of a pinboard covered in documents and brochures. The Powerpoint slide is titled ‘Improving Access to Care and the Journey for Māori and Whānau With Diabetes’. Below the title is a map of the west coast of the South Island of New Zealand. Different towns and places along the coastline are noted with named red dots – Karamea, Westport, Punakaiki, Greymouth, Hokitika, Franz Josef and Haast. Next to this map is a series of bullet points in black text under the heading ‘West Coast PHO’.**

* **7 Practices (plus 8 rural clinics)**
* **6 VLCA, 1 non VLCA**
* **4 are WCDHB owned**
* **≈ 30,000 patients**
* **Covering 513km**

**Along the bottom of the slide is the blue-and-green logo for the Health Quality & Safety Commission New Zealand – Kupu Taurangi Hauora o Aotearoa. Beside this is a logo in a metallic font for Ko Awatea: Health System Innovation and Improvement.**

Audio

(Pauline): Kia ora. I'm Pauline Ansley, clinical manager for the West Coast Primary Health Organisation. Our project was about improving access to care in the journey for Māori and whānau with diabetes. Our population on the West Coast tends to be older people, with a lower proportion of Māori and almost no Pacific. There's proportionately more deprivation than nationally. We have higher poverty, poor literacy, unemployment, isolation and difficulties accessing health care and there's significant travel distances to main centres. There's a high level of disease burden, and we have a transient health care workforce.

**Visual**

**The next slide is titled ‘Problem Statement’ in blue, in a pale-pink banner.**

* **Review of WC Diabetes care against the National Standards identified areas for improvement, supported by:**
	+ **Lower than target DAR rates (76 percent)**
	+ **Inequitable engagement (68 percent Māori, 73 percent Indian/Asian)**
	+ **Significant number of people (35 percent[109]) with poor diabetes control (HbA1c >64)**

**In the bottom left corner of the slide is a pressure gauge labelled ‘Diabetes level’, with its needle vibrating in the red ‘Alarming’ zone.**

Audio

We identified our problem through data analysis, with 23 percent of our diabetics not being reviewed and were having minimal contact unless they were having emergencies or complications. There's also suboptimal clinical care, with 47 percent having elevated HbA1cs, 67 percent with a raised cholesterol, 58 percent on statin, 60 percent with elevated blood pressure, 45 percent with elevated urine creatinine and 63 percent who are only appropriately medicated. And also, we have an additional 1200 pre-diabetics.

**Visual**

**The next slide is titled ‘Aim Statement’. Black text in the middle of the slide reads, ‘To reduce the average HbA1c level of Māori patients at Buller Medical with diabetes and an HbA1c above 64mmol/l by 20 percent from 93mmol/l to 74.4mmol/l].’ In the bottom left corner of the slide is a gold percentage symbol. The diagonal line of the symbol ends in an arrow pointing down.**

Audio

Our aim was to achieve equity for Māori. We started in April 2018 with a full team, and we completed some PDSAs, but then due to staff shortages and a key nurse leaving our project team, by Christmas, we had made very little gain. So we changed our focus

to just on Māori. And Poutini Waiora, our Māori providers, saved the day by being able

to work with this cohort. The rest of the presentation is on this.

**Visual**

**The next slide is titled ‘Diagnose the problem – Ishikawa Diagram’. Below this is a blue horizontal line starting with a dot and ending in an arrow. Thinner blue lines shoot off from this line, connecting to different subheadings in black text.**

* **Environment**
	+ **Uncomfortable in clinical environment**
	+ **Location base**
	+ **Distance**
	+ **Weather**
	+ **9-5 hours**
	+ **15min apt.**
* **Staff**
	+ **Locums – lack continuity**
	+ **Cultural responsiveness**
	+ **Misdiagnosis**
	+ **Shortages**
	+ **Non-judgemental**
	+ **Level of communication**
	+ **Supervision**
	+ **Training.**
* **Patient**
	+ **Fear**
	+ **Lack of understanding**
	+ **Not having support from family**
	+ **System not user-friendly**
	+ **More education**
	+ **Denial**
	+ **Plain speak**
	+ **Trust**
	+ **Financial barrier**
* **Equipment/resources**
	+ **Reliable**
	+ **Accessible**
	+ **IT systems difficult**
	+ **Confusion for patients**
	+ **Transport**
* **Training/education**
	+ **Patient/whānau**
	+ **Staff**
	+ **Insulin start experience**
* **Processes**
	+ **Referral pathway**
	+ **Time constraints**
	+ **Accessing**
	+ **Lack of integration**
	+ **Poor QI**

**The arrow the horizontal line ends with points towards text that reads, ‘Factors contribute to continual low annual review rates, inequity and poor diabetes control.’**

Audio

OK, diagnosing the problem with our Ishikawa diagram, we did originally add an initial stakeholder workshop. Attendees were including consumers and stakeholders from across the coast. They identified the factors that contribute to continual low annual diabetes review rates, inequity and poor diabetes control.

**Visual**

**The next slide is titled ‘Diagnose the problem – Affinity Diagram’.**

* **Improved care coordination and delivery**
	+ **Wrap-around services**
	+ **Quality of appointments**
* **Timely access**
	+ **ADRs completed on time**
* **Improved patient experience and relationship**
	+ **Continuity of care with the same clinician**
	+ **Education packages provided**
	+ **Lifestyle opportunities discussed and referred**
* **Accurately identified population**

**Beside the text is an image of four interconnected puzzle pieces, one blue, one green, one red and one yellow.**

Audio

We used our affinity diagram to develop our primary drivers for our driver diagram and our theory of change. Our key themes were improved care coordination and delivery, timely access, improved patient experience and relationship, and accurately identified population.

**Visual**

**The next slide is titled ‘Capturing the Patient Experience’.**

* **Whakakotahi regional stakeholder meeting – consumers present – 2 local diabetic patients, one who is chair of local consumer working group.**
* **2 Māori consumers on project team – involved in PDSAs**
* **Patient questionnaire – 35 patients surveyed about DAR experiece – at the start**
* **Continued pateint feedback post-intervention,**

**In the bottom left corner of the slide is a group of orange human figures, all with a speech bubbles above their heads reading, ‘Me!’**

Audio

Consumers were involved from the beginning of the project to capture their experience

and what their needs are. This was through patient survey and consumer representatives on our project team.

**Visual**

**The next slide is titled ‘Storytelling: the voice of the patient’.**

* **Very satisfied with the nurses and DAR**
* **Like to see the same doctor or nurse**
* **Feel involved in decision-making**
* **Want more information on medications and side effects, diet, exercise, foot care, diabetes and supports available in the community**
* **Know what they should/shouldn’t be doing**
* **Like the support from Poutini Waiora**

**In the bottom left corner of the slide is a stamp reading ‘100 percent Patient Value Added’.**

Audio

Patients were largely happy with the annual reviews, and they like continuity of care.

**Visual**

**The next slide is titled ‘Building Up a Change Package’. A large green circle contains text that reads ‘Change Package’. Five spokes spread from this circle, connecting it to smaller, brightly coloured circles. The first smaller circle is darker green and labelled ‘Increase lifestyle programme referrals’. Beside this is a series of bullet points.**

* **Staff education**
* **Advertising/newsletters**
* **Retinal screening clinic**
* **Single point of entry/triage (This bullet point is in bold.)**

**The bulletin points are encompassed by a bracket and labelled ‘done’.**

**The second smaller circle is blue and labelled ‘SECO training for nurses’. Beside this is a series of bullet points.**

* **Diabetes cases – done (‘Done’ is in red.)**
* **Foot care**
* **Motivational interviewing**
* **Health literacy – done (‘Done’ is in red.)**

**The third smaller circle is pale purple and labelled ‘Patient education package/s’. Beside this is a series of bullet points.**

* **Medication leaflets – done (This bullet point is in bold, and ‘done’ is in red.)**
* **Foot care leaflets**
* **Healthy eating/label reading**

**The fourth smaller circle is red and labelled ‘Update diabetic annual review form’. Beside this is a series of bullet points.**

* **Update DAR form – done (‘Done’ is in red.)**
* **Medication Audits**
* **Align PHO/Pharmacy LTC – started/delayed (‘Started/delayed’ is in red.)**
* **Pharmacist support in practice – MURs**

**The fifth smaller circle is yellow and labelled ‘Increase appointments’. Above this is a series of bullet points.**

* **Drs phone triage**
* **Patient portal**
* **HML phones**
* **E-prescribing – done (‘Done’ is in red.)**

Audio

The highlights of our change package are a single point of entry for lifestyle referrals from a dietician and green prescription and medication leaflets for patient education. And I have to acknowledge the Health Navigator website for these. SECO training for nurses – stands for safe, effective clinical outcomes – and this was a training we conduct with real nurse specialists, and we've adapted to practice nurses focusing on long-term conditions in diabetes cases. Health literacy training is ongoing to our practice teams.

**Visual**

**The next slide is titled ‘Outcome measure: HbA1c’. Next to this title is a wooden ruler at an angle with white text on it that reads ‘Measure’. Below this is a line graph titled ‘Other Average HbA1c’. The Y-axis of the graph is labelled ‘Average HbA1c’. The X-axis is labelled ‘Month 2018 – 2019’. The line of the graph goes up and down, with a high spike at June 2019. Plotted points along the line are labelled ‘Dietician newsletter retinal clinic’, ‘ERMS & SPOE’, ‘Staff shortages Aug – October’, ‘Staff prompts’, ‘Poutini Waiora Hui’ and ‘Poutini Waiora Clinic started’.**

Audio

For our outcome measures, we measured HbA1c, and for our total population, the median was 79, and the average being 80. The original goal for us was to reduce HbA1c from 83 to 74, aiming for a 10 percent reduction.

**Visual**

**The slide updates with a line graph titled ‘Māori Average HbA1c’. The Y-axis of the graph is labelled ‘Average HbA1c’. The X-axis is labelled ‘Month 2018 – 2019’. The plotted points along the line have much steeper, higher peaks and sharper, deeper troughs. The labelled points on the graph are the same as the previous slide – ‘Dietician newsletter retinal clinic’, ‘ERMS & SPOE’, ‘Staff shortages Aug – October’, ‘Staff prompts’, ‘Poutini Waiora Hui’ and ‘Poutini Waiora Clinic started’.**

Audio

For Māori, our outcome measure of HbA1c, the median is 93. The average was 97. And our goal was to reduce by 20 percent to 74 millimoles per litre. This is usually just for one, two or three people. So, therefore, one person with a poor outcome greatly affected the results.

**Visual**

**The slide updates with the title ‘Process Measure: overdue DAR’. Below this is a line graph titled ‘Overdue: DAR Māori’. The Y-axis is labelled ‘Number of Māori with overdue DAR’. The X-axis is labelled ‘Monthly 2018 – 2019’. The line of the graph steadily rises, reaching its highest point at February 2019. The line drops down drastically and suddenly after a plotted point labelled ‘Poutini Waiora Clinic started’.**

Audio

Our process measure for Māori was measuring those overdue for diabetes annual review. So, of a cohort of 32 people, there appeared to be a trend starting, as you can see on the graph, five data points up or down. And we did achieve a shift with this we're continuing to measure following.

**Visual**

**The slide updates with the title ‘Process Measure: Lifestyle T2’. Below this is a line graph titled ‘Referrals with Type 2 Diabetes Māori’. The Y-axis is labelled ‘Number of Referrals’. The X-axis is labelled ‘Month 2018/19’. On the graph, June 2018 is labelled ‘Retinal screening’, and March 2019 is labelled ‘PW clinic started’. The line of the graph goes up and down.**

Audio

Our other process measure was lifestyle referrals for people with type 2 diabetes. The numbers are small, but the referrals for Māori are more consistent, and they increased as time went on.

**Visual**

**The slide updates with another, similar-looking line graph, this time titled ‘Attendance with Type 2 Diabetes Māori’. The Y-axis is labelled ‘Number of attendees’. The X-axis is labelled ‘Month 2018/19’. March 2019 is labelled ‘PW clinic started’, and July 2019 is labelled ‘No dietician’.**

Audio

We also measured our attendance for type 2 diabetes at lifestyle clinics for our cohort of people, and people appeared to be attending the clinics.

**Visual**

**The next slide is titled ‘Process Measure: Whānau Ora’. Below this is a bar graph titled ‘Total Number of Additional Wrap-around Services and/or Referrals Generated’. Numbers going up in intervals of two run up the Y-axis from 0 to 16. Each individual bar is labelled along the X-axis as follows.**

* **Flu vaccination – 10**
* **Shingles vaccination – 6**
* **Cervical smears – 2**
* **Foot checks – 16**
* **WINZ – 2**
* **Budget advisory – 3**
* **Quit advice – 10**
* **Cessation referral – 0**
* **Dietician referral – 0**
* **Podiatry referral – 8**
* **Retinal screening – 4**
* **GRx referral – 2**
* **Kaiarataki referral – 6**
* **CCCN referral – 2**
* **DNS referral – 2**
* **Enrolled LTC – 16**
* **Comorbidity – 8**
* **Physio referral – 2**
* **Orthotics – 2**
* **Appt transport – 4**
* **Pre-diabetics – 2**
* **GP apt – 4**
* **Dental – 2**
* **Food parcel – 3**
* **Housing NZ – 2**

Audio

Our process measure was of Whānau Ora wrap-around services that were provided by Poutini Waiora to patients. The data was for 15 people who had been seen to date with this presentation out of the cohort of 32 people. Some of these indicators were underreported, such as GP appointments, WINZ, food parcels, brief advice, cessation referrals, dietician and Green Prescription referrals. They are often declined or underreported.

**Visual**

**The next slide is titled ‘Jan 2018 – Jun 2019 Case 1’. Below this, black text reads, ‘Mental health and anxiety – seclusion (DNAs), wouldn’t answer phone or respond to texts, has mobility issues.’ Below this is a bar graph titled ‘Health presentations’. The Y-axis is labelled ‘Number of presentations 2018/2019’, with numbers going up in intervals of two from 0 to 20. The X-axis is labelled ‘Types of presentation’, with each bar of the graph labelled as follows.**

* **GP presentations, which goes to the value of 18 on the Y-axis**
* **DAR overdue, which goes to the value of 15 on the Y-axis**
* **Poutini (May 2019), which goes to the value of 8 on the Y-axis**
* **ED presentations, which goes to the value of 5 on the Y-axis**
* **DNA, which goes to the value of 4 on the Y-axis**
* **Other, which goes to the value of 4 on the Y-axis**
* **Hospital admissions, which goes to the value of 2 on the Y-axis**
* **Poutini DNA, which goes to the value of 2 on the Y-axis**
* **District Nursing, which goes to the value of 2 on the Y-axis**

**In the bottom left corner is a cartoon of a grey-haired woman in a brown cardigan, grey polo shirt and pink skirt.**

Audio

One of our case studies was a lady with mental health and anxiety issues. She also lived in seclusion and had frequent DNAs. She wouldn't answer her phone or respond to texts, and she had mobility issues. She had two hospital admissions and five ED presentations, 18 GP contacts, four 'did not attends', and her diabetes annual review

was overdue by 15 months, and she also had four other contacts with health professionals during the previous year. She'd never attended retinal screening.

**Visual**

**The next slide is titled ‘Case 1 Outcomes’.**

* **Referral to PW support**
* **Home visits, completed survey about this experience.**
* **Patient has self-increased insulin to improve BGLs (‘self-increased insulin to improve BGLs’ is in bold), engaging with PW and answering calls and text messages.**
* **Has decreased hours with mental health since gaining support from PW and with improved well-being.**
* **Supported to orthotics and got shoes for walking – comfortable for walking outside now. Attended physio, now has taxi chits, mobility parking sign.**
* **Beginning to increase independence and self-care with tasks. (This bullet point is in bold.)**
* **Attend retinal screening clinic, on recall in 6 months.**
* **Phones to cancel appointments rather than just DNA.**

Audio

The outcomes for this lady were some improvement in her health outcomes. She'd been working with Poutini Waiora from May 2019 to the end of that year, and she'd had eight contacts with them, including her diabetes annual review at that time. She had three DNA attendances that she'd had a GP review with Poutini Waiora multiple times, and she had lots of whānau issues that were affecting her attendance. She declined assistance from the Poutini Waiora team at the end of this time, saying that she could manage herself and was feeling more confident with increasing her self-care.

**Visual**

**The next slide is titled ‘Case Study 1 Patient Feedback’.**

* **‘Very comfortable… full review’**
* **‘Poutini is all about whānau, and from previous experience, there was little or no care. Poutini offers so much support.’**
* **‘Because of PW, I now manage my diabetes so much better, and happier to do so.’**
* **‘It impacted me in a more positive light, therefore my whānau is greatly impacted.’**
* **‘Nothing could be improved. PW has been extremely supportive in my mental and physical health.’**
* **‘Medication sheets were helpful and easy to understand.’**

Audio

Her feedback was very positive, and she much appreciated the support she got from Poutini Waiora.

**Visual**

**The next slide is titled ‘Challenges’.**

* **staff shortages (staff turnover/winter crisis)**
* **maintaining momentum (protected time and practice engagement barriers)**
* **Funding/resourcing the model**
* **Data (obtain manually and prone to flaws through practice user error)**
* **No time allocated by practice**
* **Buy-in from wider team**
* **Sponsor/manage support**
* **Practice environment and culture**
* **IT – just obtaining data**
* **Rapid changes across Buller Health**

**In the bottom left corner of the slide is a photo of a green road sign, bearing white text that reads ‘Challenges’.**

Audio

The key challenges we had were staff shortages and maintaining momentum. A lot of this was the inability to have protected time for project members to work on the programme. It was very difficult to achieve in the practice. We had a high turnover of long-term nursing workforce and a new model of integrated nursing care being introduced to the practice, which also made it difficult to get time to work on the project. We had three Buller Health managers during the project time, and leadership support was lacking. Poutini Waiora involvement has meant the project could continue, otherwise it would have just fallen over.

**Visual**

**The next slide is titled ‘Key Successes’.**

* **Poutini Waiora saved the day! (This bullet point is in bold.)**
* **Engaging GP/weekly case reviews (This bullet point is in bold.)**
* **Team inspired**
* **Positive patient feedback**
* **Continuity of care (‘Continuity of care’ is in bold), holistic wrap-around support improving patient well-being and independence (‘patient well-being and independence’ is in bold)**
* **Engaged some difficult-to-engage patients**
* **Reduction in overdue DARs (This bullet point is in bold.)**
* **Spread (‘Spread’ is in bold) – Reefton and Greymouth\***
* **Spread (‘Spread’ is in bold) – other LTCs**
* **Alliance Leadership Team (ALT) support for the model for High Need groups and address diabetes in workstreams**

**In the bottom left corner of the slide is a photo of a woman on some rocks in a bay. She holds a giant net.**

Audio

All of these key successes are important, but particular highlights are having a dedicated GP for case reviews and the speed of the project to other practices. An example with the spread is the Greymouth team that have a nurse practitioner and a GP with the Whānau Ora nurse, a pharmacist, a diabetes nurse specialist involved in the team. A case study is an example of a man who was overdue for a CBRA, and he was visiting the practice for a script. The Whānau Ora nurse saw him at the practice and said, 'Get bloods off that man.' The GP did that, and the result was a new diagnosis of diabetes. By the time the man went to pick up his usual prescription from the pharmacy, the script had been sent with an added diabetes medication. The pharmacist advised the patient that he had a new diagnosis of diabetes and gave him medications with detailed education before the Whānau Ora nurse or GP had even been able to talk to him to give him a diagnosis. The nurse home-visited him the next day to discuss with him, and he advised her that he'd been fully informed by the pharmacist. The nurse has arranged for follow up with him in the ED, because he works during the week. So the team were considering how they could continue to provide the follow-up care for him. And the ED had consented for this to happen through them. An update from December 2020 is that Poutini Waiora are still tracking the Buller Māori cohort of 32 patients. Out of these, 29 have engaged. Some have slipped back into old habits, but they're not embarrassed about coming to see the team and tell them. The GP has left, so GP support is currently only available via regular locum. Reefton practice is still going well. The private practise in Westport had a change of ownership at the beginning of the COVID lockdown. They've had some teething problems with the new staff understanding the purpose of the project and the collaboration with Poutini Waiora, but this is being worked out. And dietician support has been through the kaiarataki, as many of the patients don't want to see the dieticians. So the dietician has been providing advice through the team members, and this is working well.

**Visual**

**The next slide is titled ‘Lessons Learned’. In the top right corner, different, brightly coloured human figures sit around a boardroom table, each with a different-coloured puzzle piece in front of them. In the centre of the table is a blue jigsaw puzzle with a piece in the middle missing. Black text below the title reads ‘Process’.**

* **Keep it simple, go slow (while maintaining progress)**
* **Learn to approach change methodically**
* **Team learning about quality improvement**
* **Staff and patient co-design – added value**
* **Instrumental to involve project in workstream plan**

**Below this, black text reads ‘People’.**

* **Need most influential people involved – kaiarataki/kaupapa Māori nurse/DNS/GP**
* **Continuity of care, structured approach and time to provide wrap-around care are key (kaiarataki role).**
* **Patient stories motivate people.**
* **Going through medicines and health literacy in a way they understand makes a big difference.**

Audio

The lessons learned were mainly co-design at the beginning was empowering and it added value, and again, patients want continuity of care. A structured approach and adequate time to coordinate care is definitely needed.

**Visual**

**The next slide is titled ‘The End – but only the beginning’. In the middle of the slide is a pale-yellow rectangle resembling a Post-it note. It reads, ‘Any questions?’ ‘Any’ is in red, and ‘questions’ is in black, underlined with a red line.**

Audio

Any questions?