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Dunedin Office
229 Moray Place
Phone: (03) 474 8040
Fax: (03) 474 8582
Email: Healthpac_m@moh.govt.nz

Performance Monitoring Return - Whanganui Regional PHO

Provider Number: 585463
Agreement Number: 296837/02 Whanganui District Diabetes Services
Agreement Term: 01 July 2005 to 30 June 2010
Agreement Manager: Tracey Schiebli
Agreement Deputy Manager: Patricia Harvey
Agreement Funder: Whanganui DHB

Reporting Period		
Start Date	End Date	Due Date
01 January 2007	31 December 2007	29 February 2008

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Executive Summary

This report represents eighteen months of performance against the primary led Whanganui Regional Diabetes Programme contract objectives. The challenges of adopting a primary led programme have been varied and expectations have at times not been met but the learning has been immense. Moving a programme that was essentially secondary hospital based to a responsive more accessible primary based programme requires a behavioural change. Clients are required to take more ownership for their condition given some of the previous barriers for not attending appointments have been eliminated such as the service now being provided within an accessible location in an environment that generally they feel comfortable (confirmed in satisfaction surveys). Clinicians have had to change their thinking or perhaps not in some cases, but essentially the expectation of a more responsive, accessible, value added outcomes are a given. It's not about the clients and their families coming to the clinicians it is about the clinical experts meeting their clients in an environment that is familiar to them so in the case of this programme it has included General Practice hubs, Rural health centres, Iwi Health providers, Marae and peoples homes.

So, one must examine the results and again as in the past the outcomes for people with 'other' ethnicities has in most cases exceeded expectations, for Pacific Island people there has been a slight improvement and for Māori again the disparity remains with many of the targets not being met. The Diabetes Governance Group has continually debated this issue and it appears that a number one priority is about the clinical team establishing a relationship with the client, their whanau and others that are significant in the client's life to influence a change in behaviour and attitude to lifestyle. This is not just the Diabetes Programme responsibility but requires a continuum approach that includes health promotion, education, public policy change and engagement of all the sectors including local government, community groups, housing and education as examples.

The Diabetes Programme stakeholders have reviewed their strategy and have a clear vision for the way forward. There is a willingness to continue to be innovative and to work with stakeholders to ensure the right people are involved in achieving the desired solutions. This is not a 'quick fix' and each year very effective strategies and support structures are developed to ensure the people closest to the clients are educated and have consistency in message, that the general practice teams maximise the opportunities that present to them to ensure that clients have access to free annual checks, have regular medication review and are referred to the clinical experts to ensure best practice standards are being met. The programme recognises that Iwi providers have existing relationships with people that generally are not comfortable in accessing mainstream services so there is a real desire to work closer with providers to broker more effective outcomes for Māori.

The Whanganui Diabetes Governance groups recognise that we are all on a journey and welcome the readers to measure our progress in 2007.

Judith MacDonald
Chair
Whanganui Regional Diabetes Governance Group

Whanganui District Diabetes Service Background

The impact of diabetes in New Zealand is significant and will become more so as the prevalence of type 2 diabetes increases. The prevalence of known diabetes across the population of New Zealand is currently estimated at around 4%; however the Diabetes Association estimates the actual prevalence to be 7% due to the level of undiagnosed people with diabetes. Within the population the prevalence of diabetes in Māori and Pacific populations is around three times higher than for other New Zealanders.

The Whanganui District Health Board (WDHB) contracted Whanganui Regional Primary Health Organisation (WRPHO) to coordinate and facilitate the management of a Regional Diabetes Service for the Whanganui District Health Board (WDHB) area. The close of 2007 represents eighteen months of contract holding for WRPHO. The contract has been renegotiated for a further three years until June 2010.

The principles of the Whanganui Regional Diabetes Programme are to:

- Demonstrate added value / improvement from the prior configuration
- Affordable and efficient
- Demonstrate integration across service components and coordination across the region
- Provide quality services for the population, e.g. effectiveness, appropriate, continuity of service
- Meet needs of target groups particularly Māori
- Align with the WDHB Health Priorities and the MOH Diabetes Tool Kit
- Supported by Governance and Clinical stakeholders

It is the intention of all stakeholders to work together to address disparity in health that exists for some of our community particularly Māori and Pacific Island people. In addition, addressing inequality in access and barriers to diabetes health services for rural communities is also a priority.

The Diabetes Programme service components and areas of responsibility are:

- Diabetes Education and Management – Diabetes Nurse Educator
- Podiatrist Services
- Kaupapa Māori Diabetes Educator
- Annual Diabetes Checks
- Education Sessions

Diabetes Targets

Diabetes target setting methodology

The system used to determine the process for regional diabetes target setting has been altered for the 2008 year to more accurately reflect the actual number of people with diabetes in the region. Previous targets were set using census data and an estimated prevalence of diabetes percentage. Although this method provided a figure to benchmark against and aim towards it did not show actual data, as the percentage used to estimate the number of people with diabetes could not be verified.

The new system uses a combination of information from primary and secondary care to show the actual numbers of those who presented with diabetes in our area¹. This enables the governance group to measure our screening performance and set future targets against 'actual numbers'.

This change in methodology has shown that the actual number of Māori in our region with diabetes is actually lower than previous years estimates had projected. The 2007 expected number of Māori with diabetes in Wanganui region was 779; this is compared to the 2008 figure of 691. This highlights that previous targets set by the governance group for Māori may not have been a good performance measure as the target was set using estimates but performance was measured using actual screenings done.

Retinal Screening

Retinal screening has previously been a performance target for the diabetes contract; however from 2008 the Ministry of Health (MOH) will be measuring only Diabetes Detection and Diabetes Control. Although retinal screening has been removed from the programme as a performance measure the diabetes governance group believe that this is still an important service to monitor and seek to continually improve hence the decision to maintain this indicator as information only.

Cardiovascular Disease (CVD) risk assessment screening

It is the intention of the MOH to eventually introduce a CVD/Diabetes screening indicator as a third performance measure. This indicator is the same indicator used by the Primary Health Organisation Performance Management Programme. The WRPHO Performance Management Team are currently refining practice processes and requirements for universal implementation of a CVD risk tool, which will mean WRPHO practices will be prepared for this new indicator in the next performance period. Currently there is variability in screening methods and data collection processes so consistency across PHO Practices will reduce variability in data and reporting.

¹ "Actual diabetes" is a count of all NHI's domiciled in your DHB with a hospital discharge diagnosis of diabetes, diabetes-specific medicine dispensed, 3 or more HBA1c tests in a 2 year period, or a diabetes outpatient appointment.

Diabetes Detection and Follow up – M20010

This service is provided through free annual diabetes checks completed at the patient's general practice. At the beginning of each calendar year the Diabetes Governance Group recommends to the WDHB the target number of people to be checked. During 2007 WRPHO implemented a number of initiatives aimed at increasing the uptake of people screened.

The importance of WRPHO and Whanganui healthcare providers working together in partnership to achieve a healthy population and meet the contract targets has been one of the key aims of the diabetes governance group. One initiative aimed at increasing the actual number of people screened is providing general practice teams with feedback reports on their progress throughout the year. This data was given with the previous years screening rate to enable practice to compare the year's performance and make changes where necessary.

Along with this feedback report was the generation of practice specific lists of Māori and Pacific Island patients who were overdue for their Annual Diabetes Checks (ADC). This list was given to the appropriate practice who then actively addressed the list and where possible managed to action each patient identified. WRPHO have received positive feedback from both providers and local diabetes teams on this method of targeted screening.

WRPHO established Practice Facilitator roles in July 2007 and since this date have implemented a number of strategies aimed at increasing best practice processes. One of the key projects for 2007/08 is the establishment of a CVD screening tool for the Performance Management Programme. The Practice Facilitators have installed this software at one pilot practice. Within the implementation process practices optimise patient recalls for services which include annual diabetes checks. As these systems and processes are organised the patient journey through the service will be improved, which is intended to result in a drop in the level of patients who do not attend appointments thus an increase in screening towards the yearly target.

As stated above WRPHO provide practices with a practice specific list of those patients overdue for their annual diabetes check. This data provided is generated from the WRPHO diabetes register. The most accurate patient information is at the general practice within the patient's electronic health record. In 2007 the diabetes team generated a tool that enables practices to generate a list of patients who are overdue for their diabetes screen. The Practice Facilitators have distributed this tool to a number of practices with positive results.

2007 Performance against target

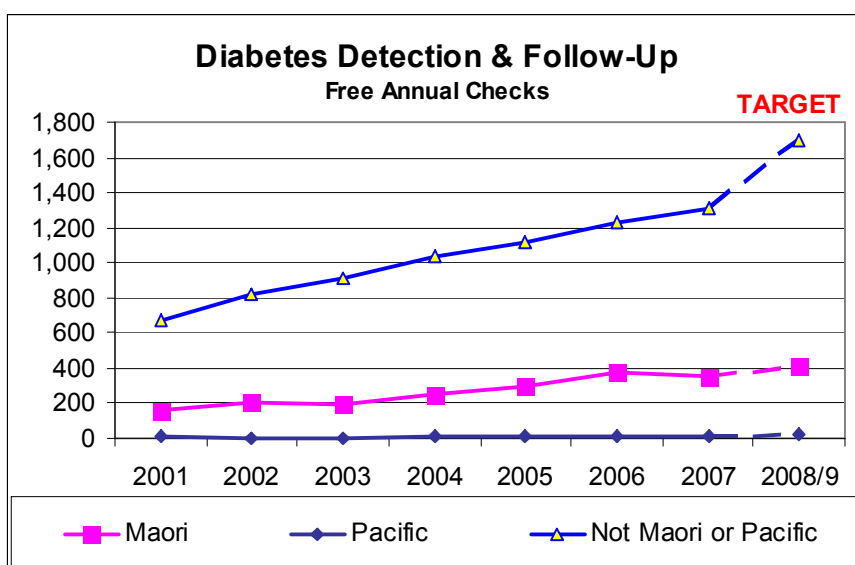
The performance target for diabetes detection and follow up are set by ethnicity, i.e. Māori, Pacific Islander and Other.

Annual Diabetes Checks for the Period 1 st January to 30 June 2007			
	Target for 2007	Checks Completed	Performance in relation to target
Māori	468	356	112-
Pacific	21	15	6-
Other	1208	1331	123+
Total	1697	1702	5+

This table shows the end of year performance for the indicator. The Māori population indicator target was not achieved in 2007; however it is important to note that WRPHO believe the 2007 target to be an unrealistic representation of the actual percentage of Māori screened as noted in the target setting methodology section above. It is the belief of the Diabetes Governance Group and WRPHO that the 2008 target is a more accurate and achievable goal.

Although the target for Pacific Islanders was not achieved the actual number of Pacific Island people screened has increased by 50% from 2006. This increase is mainly attributable to establishing an additional diabetes nurse educator who has strong ties to the Pasifika community. To further progress the positive results in 2008, WRPHO has employed a Pacific Island Health Worker who will focus on supporting people to access screening and to provide education and support to encourage successful implementation of nutrition and exercise programmes for the Pacific Island communities.

The 'other' population ethnicity group has exceeded the target set by the diabetes governance group by 123 checks for 2007.



The chart above shows the performance of this indicator since 2001, which reflects the improvement that has been made.

ADC Performance Comparison 2005 - 07

The total number of annual diabetes checks completed in 2007 is slightly up on 2006 by 77 checks. There has been an increase of checks for Pacific Island and Other ethnicities however it is disappointing to report that annual diabetes checks for Māori have decreased by 34 when compared to 2006 as shown in the table below:

ADC Comparison 2005 to 2007			
Ethnicity	2005	2006	2007
Māori	294	375	356
Pacific Island	12	10	15
Other Ethnicities	1115	1231	1331
Total	1421	1616	1702

Despite considerable investment in media adverts, editorials, campaigns and a two month radio promotion of free annual diabetes checks, this has not resulted in an increase in uptake of annual diabetes checks by Māori. The Diabetes Governance Group recognise that creative strategies are required for future years if the disparity between Māori and other ethnicity groups is to be reduced.

2008 ADC Targets

The Diabetes Governance Group have set targets (pending WDHB approval) based on data analysis of the previous years results and utilising new target setting methodology.

Diabetes Detection and Management			
Ethnicity	Expected number with diabetes in 2008	Target percentage for 2008	Actual number of people to screen
Maori	674	60%	401
Pacific Island* (MOH target)	64	50%	32
Pacific Island (Local Target)	64	33%	21
Other Ethnicities	2084	80%	1670
Total	2821	-	2092

*The Ministry of Health have restrictions around the flexibility of setting Diabetes targets. The change in target setting methodology has provided us with data on which to set our targets that is different to that used in previous years however we are unable to lower our targets for 2008 to represent a realistic approach.

For example, in 2007 the diabetes governance group expected that there were 42 PI with diabetes (according to the MOH toolkit at that time) so had set a realistic target of 50% to be screened i.e. 21 PI with an ADC. At the end of 2007 we had screened 15 PI, which is an improvement on 2006's performance and a movement towards target. The new 2008 toolkit highlights that there are in actual fact 64 PI to be screened. The diabetes Governance Group believes that we can yet screen 21 PI in 2008 so set a target that represents this. However, due to the new toolkit provided this target is now inappropriate as it shows a target decrease from 2007 to 2008. This is not the case, the only variable is the data used to set the targets.

The target setting tool provided by MOH states that "the targets you set should be achievable, realistic and should improve equity for Maori and Pacific people." We feel that the restriction placed on our ability to set targets contrasts this statement.

The Ministry of Health have allowed WRPHO to create a rider on the target which we can work towards locally. This is outlined above as 'local target'.

Diabetes Management

This indicator measures the percentage of those who have had their annual diabetes check who have an HBA1c<8%. The information is collected and analysed through the annual diabetes check data received by WRPHO. The diabetes management indicator measures the percentage of patients with diabetes that have had an annual diabetes check and have good blood sugar control. It is worth noting that diabetes is a degenerative disease and as the person ages there is a probability that HBA1c increases over time.

The diabetes governance group Māori target set for 2006 was met during that performance period. In response to this success, the target was increased to improve on that year's performance. The 2007 performance did not meet target as shown in the table below.

Diabetes Management Performance in relation to target			
Ethnicity	2007 target	End of year result	Performance in relation to target
Māori	75%	61%	14%-
Pacific Islander	82%	80%	2%-
Other	82%	80%	2%-

Although the targets for Pacific Islander and Other did not the achieve target, performance was a mere two percent short. So for these two ethnicity groups for a majority of the patients who had had annual diabetes check (80%) there was relative good control of their condition at the time. In contrast for Māori, 39% of people that had an annual check were reported as having a higher than acceptable blood sugar reading.

2008 Diabetes Management target

The diabetes governance group recommend the following targets for 2008:

Diabetes Management	
Ethnicity	Target percentage of people with good diabetes control i.e. HBA1c<8%
Māori* (MOH Target)	75%
Māori (Local Target)	70%
Pacific Island	82%
Other	82%

* We are restricted here by the targets set for the 2007 period. The Ministry of Health have indicated that the 2008 target for Diabetes Control for the Maori population can not be set lower than the 2007 target. Once again this creates a situation where we have an unrealistic target for 2008.

Retinal Screening

This indicator measures the percentage of people who had a free diabetes check that have had a retinal screen in the last two years. As stated in the target setting methodology section, the Ministry of Health has decided to remove this indicator as a performance measure for 2008. As this service can have a significant impact on the quality of life for people with diabetes, the diabetes governance group have agreed that they will continue to monitor the service performance and seek methods of improving both service quality and data reporting.

This goal has been endorsed by the Whanganui District Health Board, Funding and Planning division, who have provided WRPHO with the resource to investigate the current service process from referral to screening to recall. This project is a priority for the WRPHO diabetes team for 2008.

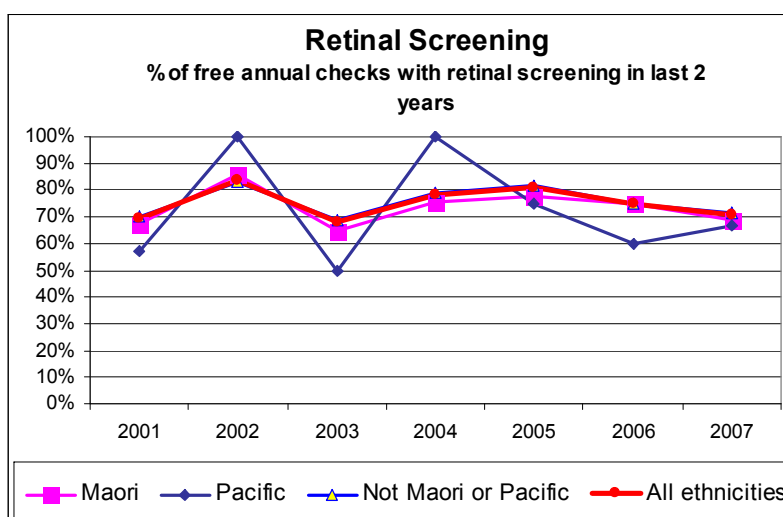
The retinal screening service provides WRPHO with statistics necessary to monitor performance. This data has been an issue for the diabetes governance group as there is currently no method of data validation to ensure the data received corresponds to those people who have had an annual diabetes check. In addition the Diabetes Governance Group wishes to validate if any inequalities in access exist particularly for Māori and rural people. Identifying levels of capacity available at the hospital provider for retinal screens for diabetes patient is also another strand of this project. Early discussions with local Optometrists are identifying what other access options might exist that may be more locally accessible for rural consumers.

2007 Performance against target

Prior to the retinal screening improved access project the diabetes team had limited ability to affect the service beyond the referral stage of the patient journey. One method used in 2007 to increase the level of eye screening was to issue practices with a list of patients overdue for a retinal screen. Practices reviewed the list and where necessary referred that patient onto the Ophthalmology department for screening.

The Diabetes Governance Group set the 2007 target at 90% for all ethnicities, justification for the high target being that retinal screening is a relatively straight forward (and critical) aspect of the free diabetes check and should be achievable. However, the 2007 results indicate that there are still a high number of people that for a number of factors are not having their eyes screened as part of the ADC. The performance for 2007 by ethnicity was:

- Māori – 69% of those with an ADC have had an eye screen in the last two years
- Pacific Islander – 67% of those with an ADC have had an eye screen in the last two years
- Other Ethnicities – 72% of those with an ADC have had an eye screen in the last two years



The graph shows the performance of retinal screening in Whanganui Region from 2001 to 2007. The graph highlights there is universally poor uptake of retinal screening for all ethnicity groups which may point to capacity issues with the provider of the service or barriers to access which are reflected in the lower than acceptable uptake.

Diabetes Podiatry – AH01006

In 2007 WRPHO and WDHB negotiated a variation to contract increasing the level of resource available for podiatry foot care. The need for this increase in resource has been highlighted in service reports and Local Diabetes Team meetings consistently through 2007. As a consequence of the resource increase, WRPHO have been able to provide additional foot care clinics for those patients who meet the referral and entry criteria to the service.

When WRPHO first became contract holders for the Whanganui Regional Diabetes Service the focus was on relocating podiatry clinics from Wanganui hospital outpatients to general practice hubs. The intention was two pronged:

- a) To take the podiatry service out of the hospital setting to venues where the patient feels most comfortable and more likely to commit to attending appointments (which in many cases is their general practice)
- b) To increase the expertise within general practice teams by having the diabetes professional easily accessible to the team

Initially the service provider contracted was Petone Foot Clinic. Although this service provider was effective in delivering the service there were limitations as to how the service could flexibly meet the needs of patients due to the geographical distance between provider and patient and other work commitments. WRPHO secured the podiatrist for three defined days per month.

The contracted provider has since relocated to Wanganui. This has presented WRPHO with an opportunity to be innovative in how the service is delivered to its communities. The programme would like to further mould the service to meet the needs of patient's particularly high needs patients for whom the barriers to access are greater. Another advantage of the provider being geographically located within the Wanganui community is that the efficiencies will be reinvested in additional clinics both within the city and rural locations.

WRPHO are intending to offer flexibility in appointment scheduling for the podiatry service in 2008 and will assess if this action will decrease the 'did not attend' rate and at the same time develop a service that reflects a strong 'patient orientated' approach rather than a 'service orientated' service.

Service Performance

The Podiatry service operates a priority need approach as demand for the service outstrips capacity and resources. All clients that meet the defined access assessment criteria are eligible to the service. The group who have priority access are those patients with complications of their feet, have existing or potential histology and meet other assessment criteria. The service was also aware that access for Māori was poor and that the did-not-attend rate for Māori was significantly higher than for other ethnic groups.

Diabetes Podiatry volumes for the period 1st January 2007 to 31st December 2007			
Ethnicity	Number of Appointments Attended	DNA actual	Annual DNA percentage
PI	2	0	0%
Māori	177	51	22%
Euro/Other	233	35	9%
TOTAL	412	86	17%

A highlight and significant success for the programme has been the improved access for Māori to the service. Forty-six percent of all appointments to the podiatry service were for Māori this is a sharp increase on previous years and contributable to the greater level of collaboration with Iwi providers, the podiatrist and Diabetes Nurse Educator in the rural areas, education programme offered to Community Health Workers and a clinician that is seen as approachable and culturally responsive.

The second indicator used by the Diabetes Governance Group to monitor service performance is the did-not-attend rate. The disparity between Māori and non-Māori is highlighted in the graph above, which reflects the need to actively target this population group. The DNA rate for Māori is twice that of non-Māori; however WRPHO believe that a continual focus in 2008 to reduce this disparity will produce an improved outcome.

Diabetes Education and Management – M20006

This contract is delivered within a collaborative framework between WRPHO and WDHB provider. The two providers operate cohesively to meet our target population through a combination of methods. The clinicians provide a primary based service accessible via general practice hubs, Rural Health Centres, Iwi based venues and within peoples homes. The WDHB clinician has successfully been credentialed and is competent to practice as a Diabetes Nurse Specialist, however currently works within the Diabetes Education and Management contract specification. The WRPHO practitioner is relatively new to the role and is mentored and supported to progress her scope of practice within this partnership model.

Overview

1. The DNS role is well established in the community for the past 18 months and has focused on general practice referrals for clients with type one and type two diabetes. The majority of the clients have complex needs with some requiring insulin treatment.
2. To reduce DNA (did not attend) rates, more flexible timing of appointments and alternative venues have been considered and offered to clients. This is naturally influenced by the workload both in urban and rural areas. The aim is to offer a combination of approaches including GP clinics, home visits, hospital based and rural clinics. The introduction of evening education sessions has increased the presentation of newly diagnosed patients accessing education.

Highlights and Challenges

The attendance and feedback from the after hours education sessions facilitated within the WRPHO facility has been very positive. The programme is facilitated by a Diabetes Nurse Educator and supported by a hospital based dietician and Green Prescription Co-ordinator. Challenges for the future are ongoing access to a dietician and how to replicate the success of this programme for rural communities within their local communities. An option is for training and education of local 'champions' who are mentored by the team to deliver a comparable education model. The uptake of this service by Māori has been positive with 44% of all those attending in 2007 being of Māori ethnicity.

The continued relationship between the Diabetes Nurse Educators and general practice teams consistently create opportunities for increased learning, networking and clarifying best practise for patients with diabetes. This was one of the intentions of WRPHO in relocating the service from the outpatient's clinic to general practice hubs and it is satisfying to see the objective has been achieved.

There is increased awareness and involvement in diabetes care with community health workers, rural nursing staff, Iwi providers and practice based teams, who have a special interest in diabetes care. Improving communication and service collaboration between these groups is an aim of the diabetes clinical and nursing forum held bi-monthly.

Issues

The WDHB Community Dietician role has been reviewed raising the threshold to access so patients with newly diagnosed diabetes or those with suboptimal control below 9% are no longer seen by this service. This has resulted in the diabetes nurses taking more dietetic responsibility in 2007 increasing nurse workloads. The dietician involvement in the diabetes education workshops has also ceased as mentioned previously. WRPHO is following this issue up with the WDHB Funder to seek a reasonable solution.

Training Needs

The Diabetes Nurse Specialist (WDHB) intends to commence study towards a clinical Masters programme.

Both Diabetes Nurse Educators plan to attend the International Diabetes Federation conference.

The WRPHO Diabetes Nurse Educator has a number of training programmes planned for 2008, which include a Smoking Cessation workshop for Pacific Islanders, Te Hotu Manawa, as well as receiving mentoring from the Diabetes Nurse Specialist throughout the year.

Review of the provision and education and management services

The diabetes education and management service has evolved over the past year mainly due to the appointment of WRPHO's Diabetes Nurse Educator. This role targets clients who do not readily access mainstream services such as Māori, PI and low deprivation clients. Throughout the year the WRPHO Diabetes Nurse Educator has given specific emphasis to networking with rural providers and Iwi organisations and this will continue to be the focus.



*Korowaitia te puna waiora
Hei oranga motuhake mo te iwi*

TE ORANGANUI IWI HEALTH AUTHORITY

Te Waipuna

2007 Diabetes Annual Report
Kaupapa Maori Regional Diabetes Educator Coordinator

Executive Summary

The Kaupapa Māori Diabetes Educator report offers a general overview of the delivery and the range of services offered to patients across the region.

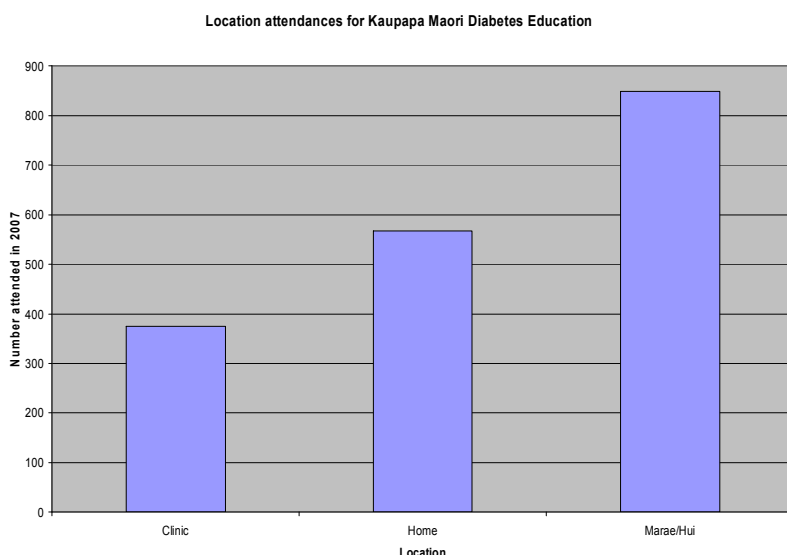
This service is designed to deliver diabetes education and management services for people with diabetes. The term 'education and management' refers to programmes that provide the skills necessary for people with diabetes to support lifestyle change and self-management of their diabetes.

Diabetes is a chronic disease where the person with diabetes must become a co-partner in the education and management process. The emphasis must be on a relationship in which health professionals and people with diabetes are genuine partners seeking together the best solutions to each person's care.

The Kaupapa Diabetes Educator service especially targets Māori, Pacific people, and other high-risk population groups to ensure the best solutions sort are tailored to the target group. Data collected during 2007 identifies that the 'hard to reach' and 'at risk' patients remain the majority of those seen by the Kaupapa Māori Diabetes Educator.

Utilisation of the service by Māori

Data from last years report, alongside this year's statistics indicate a trend upwards. Alongside 548 attendees for the 2006 reporting period, data identified for this current year of 884 attendees shows an increase in Kaupapa Māori Education services for Maori in the Region.



The Kaupapa Māori Diabetes education service was established to provide diabetes education to the target population in a manner that improves the uptake of attendances to diabetes education services. One of the differentiating factors of this role from main stream education is the location of the service delivery. The graph here indicates the number of Māori receiving Kaupapa diabetes education at either their general practice clinic, domicile setting or at their Marae (of which the majority are seen at

the Marae) The graph highlights the ability of this service to deliver diabetes education to Māori at the locations which are familiar and lower the barriers to access for the target group.

For many Māori transport and other associated factors present a major barrier to receiving diabetes education. Throughout the performance period 29% of all those seen by the Kaupapa Māori Diabetes Educator were seen within a domicile setting. This highlights the intention of the service to eliminate the barriers of access associated with clinic locations.

During 2007 there was a 90% uptake of the service by Māori reflecting the intention to target this ethnic group.

General Overview

For the best part of 2007 contractual obligations were spent building and maintaining strong linkages with Māori groups (whanau, hapu and Iwi) within the Whanganui District Health Board boundaries.

This was primarily to introduce the Regional Kaupapa Māori Diabetes Coordinator services out amongst the wider community. The sole purpose being to raise the awareness of diabetes amongst Māori and focusing on diabetes education and management.

With good network systems in place, building a strong partnership with the Whanganui Regional Primary Health Organisation by way of service delivery to Māori, Pacific Islanders and other ethnicity was important.

The role of the Kaupapa Māori Diabetes Coordinator was mainly a pivotal role linking Māori whanau and providing cultural support either for non Maori people or organizations entering areas of uncertainty such as Marae venue, Iwi organisation and private residents.

We have seen the development of Iwi health providers establishing and implementing diabetes clinics in their respective area with good results. Congratulations to Otaihape Maori Komiti. Another successful project included the 'Free Dental Check' for known diabetics registered with the Primary Health Organisations' in the Whanganui District Health Board area.

Areas for improvement

- Extend clinic hours to accommodate 'shift workers' to acquire their 'free annual diabetes check'
- Cater for people that have a phobia of needles. This adds to a high DNA rate being recorded.

Performance Indicators for 2008

It has been identified that the need for additional performance indicators for the Kaupapa Māori Diabetes Education role is needed. The Kaupapa Māori Diabetes Educator and WRPHO's Diabetes team have recommended the use of the following indicators for the period commencing April 2008:

- The Percentage of those seen by the Kaupapa Māori diabetes educator that have had an annual diabetes check
- The percentage of those seen who have had an ADC with their an eye screen in the last two years
- Number of those people seen who have had a decrease in blood pressure during the reporting period
- Number of those people who have had a reduction in weight

The indicators shown here will be tabled at the March 2008 Diabetes Governance Group meeting for discussion and endorsement.

Collaboration

Local diabetes team collaboration in service delivery:

- Podiatry Clinic (Whanganui- Te Waipuna, Otaihape (old Hospital Building), Marton (Rangitikei Health Centre), Ratana Pa.
- Otaihape Māori Komiti Bi monthly Diabetes Clinic and group sessions either at the above address, Nga Marae, restaurants and home visits.
- Ngati Rangi Education sessions only, Marae based clinic and NZ Police Sky Lodge Raetihi, home visits.
- Ngati Apa education deliver held either at home or on the Marae
- Whanganui and NgaRauru education delivered urban/rural satellite (Marae) clinics, home visits

Methodology

The key method for education delivery remains predominately through face to face contact by delivering these following workshops:

- Education
- Diabetes
- Type 1
- Type 2
- Lifestyle
- Kai
- Korikori Tinana
- Management
- Podiatry
- BGM/Device
- Medication
- Referral

While group workshops have been predominate, one on one education sessions have occurred.

Professional Development

Types of Hui attended by Coordinator:

- Hospital – Diabetes Clinical
- Group, WRPHO – Diabetes Clinical Forum
- TOIHA – Te Waipuna Medical Centre Staff & Clinical Team Hui
- TOIHA – Peer Support Group
- Taumata Hauora Clinical Forum
- WRPHO Diabetes Governance Group *may be requested to attend from time to time*

Professional Training to complete

- National Diabetes Conference
- Phlebotomy
- Health Promotion Certificate
- Audit

Information Data

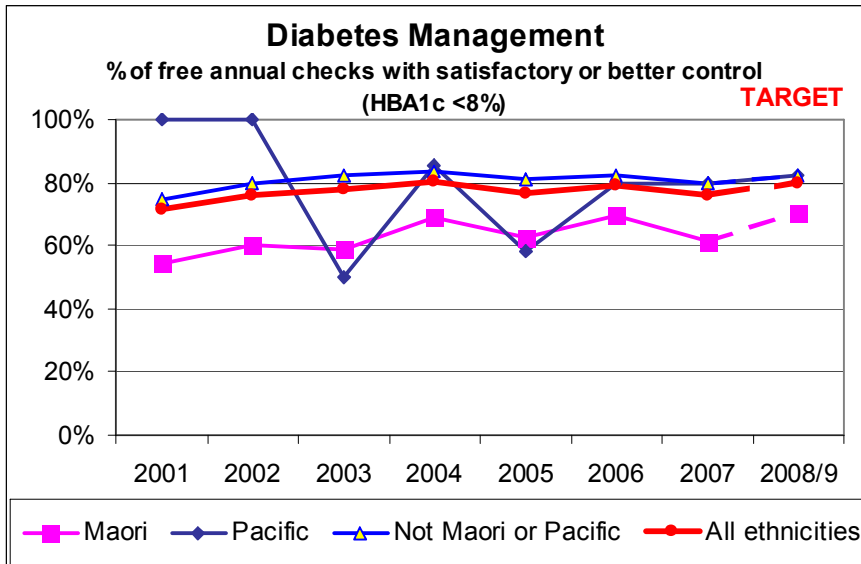
Annual Services Performed	Numbers attending
Education	433
Type 1 diabetes education	92
Type 2 diabetes education	35
Health Hui	243
Oral Health	14
Device Advice	15
General	52

Lifestyle Management Graphs

The Ministry of Health has provided WRPHO a tool to assist in data analysis of contract performance for 2001 - 2007. The graphs shown below have been generated from this tool.

Note on graphs: The Pasifika population shown in this graph radically fluctuates from between periods. This is due to the low 'actual' numbers of Pasifika people having a screen done hence slight variation to the screening 'actuals' equates to a large shift in reflected in these graphs.

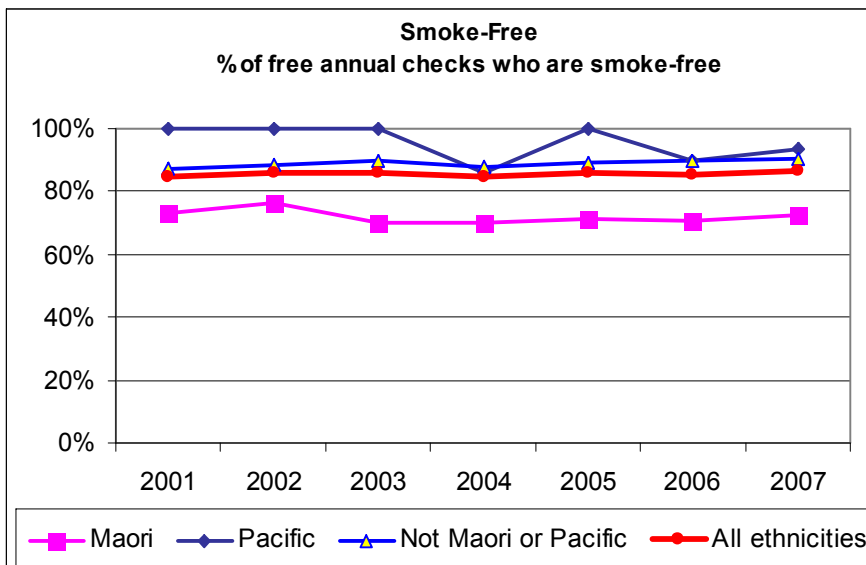
Diabetes Management



This graph illustrates the percentage of those people who had an ADC that have good diabetes control from 2001 to 2007. The Māori population has a lower percentage with good control than other ethnic groups highlighting the existing disparity in health.

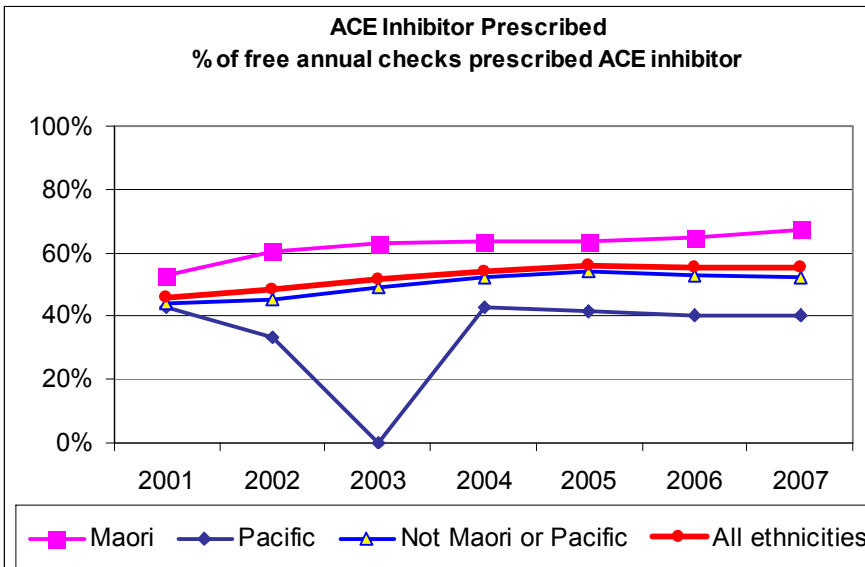
The 2008 figure reflects the target set by the diabetes governance group. The Māori target set highlights the group's intention to increase the percentage of Māori with good control and decrease the disparity between Māori and non-Māori.

Smoke Free



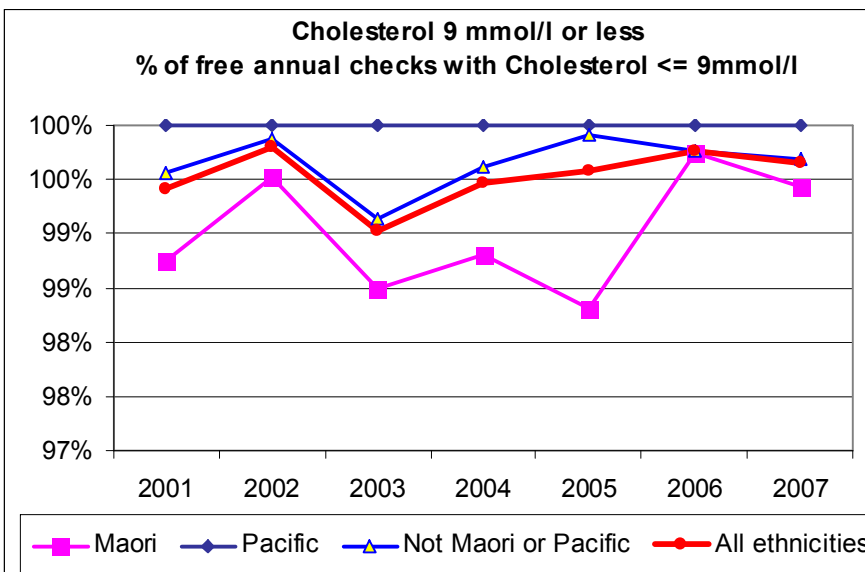
This graph illustrates the percentage of those who have had an ADC that are smoke free. The disparity between Māori and non-Māori is highlighted here. Since 2001 there has been little movement for any ethnic group, which may indicate that the smoke free strategies implemented to date have as yet not effected the population with diabetes.

ACE Inhibitors prescribed



This graph plots the percentage of those who have had an ADC that have been prescribed an ACE inhibitor from 2001 to the current reporting period. People with diabetes are at greater risk of cardiovascular disease and or nephropathy. The prescribing of ACE Inhibitors is intended to reduce the risk of this happening. The graph here shows that Whanganui providers are prescribing this medication to a greater extent to the high risk groups in particular Māori people.

Cholesterol management

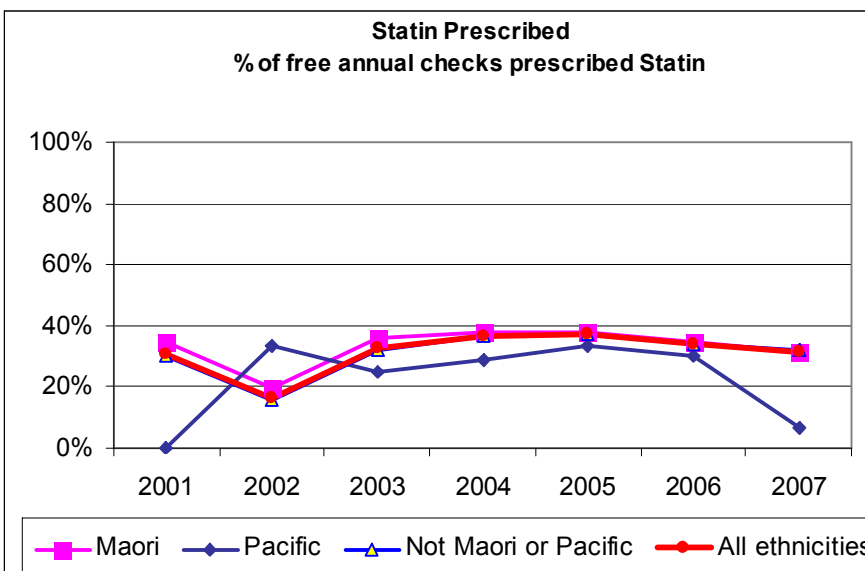


The graph here shows the percentage of those that have received a free diabetes check that have good cholesterol of 9mmol/l or less.

What is shown here is the disparity between Māori and other ethnic groups narrowing since 2001.

Note: The diabetes clinical team has suggested the use of a cholesterol indicator of 6mmol/l or less which they believe is more clinically appropriate and gives a more relevant measure.

Statin Prescribed



The graph here shows the percentage of those receiving a free annual diabetes check as having been prescribed Statin medication.

Diabetes Clinical Forum - Chair Report

This report reviews the reasons for the development of a separate governance group, the original objectives of this group, and the activities and achievements to date and the direction of the group from here.

In July 2005 the previously held LDT meetings were split and two separate governance groups were formed, namely the Diabetes Governance Group and the Diabetes Clinical Governance Group. The members of the former group are representatives from the PHO team, DHB planning and funding, rural and diabetes association reps, and consumers, with the aim of providing an overarching 'voice' on the strategic development of diabetes services with emphasis on improving access and uptake of services for Māori.

The aim of the Clinical Governance Group, comprising of health professionals and Māori health providers directly involved with the care of those with diabetes is to reduce the incidence and impact of diabetes in the Wanganui region through comprehensive clinical measurement and management of pre and diagnosed diabetes and implementation of the New Zealand guidelines. This is achieved through the development and implementation of screening processes, accessible services, education and collaborative care, in response to local demographics, data and targets set by the MOH. All of this work is supported by an ever widening team such as the DNA coordinator and health promoters plus national programmes such as HEHA.

Listed below is the range of activities/ discussions which this governance group has been involved with since its inauguration in July 2005.

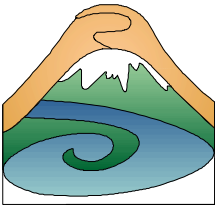
- Establishment of the group: TOR: scopes of practice
- Referral process for nursing, podiatry services, clinics/information to health professionals
- Data collection/setting targets: ADCs/MOH/KPI: Reporting requirements/PMS (Sandy Dawson) / practice feedback
- Workforce development/education DNE/ Diabetes Specialist Nurses
- Consultation / Recommendations for rural services
- Diabetes & CVD risk analysis for Māori (ADC info)
- IT processes between the DHB and PHO
- Podiatry service / referral, clinics, DNA data
- Retinal screening: Access / data
- Management and measurement of pre-diabetes
- NZGG management of Type 2 diabetes (recommendation: education training package / process designed and implemented)
- DHB research proposal
- Diabetes Services Evaluation (WRPHO) March 2006
- Diabetes Clinical Forum April 2006: first CCE meeting (77 attended)
- Diabetes Advanced Practice: CCE meeting Oct 2006
- Leading for Outcomes Workshop: development of strategic model / evaluation plan
- Welcome to Community dietician, Rawhina (Diabetes health promoter/educator, Te Oranganui), Sil (WRPHO diabetes nurse educator)
- Education / Nutrition programme for Pacific people and families
- Diabetes Awareness week: Oral health / free dental checks
- Diabetes education plan 2007
- Whakauae Research Service reports; 'Reducing Māori health inequalities and improving diabetes health outcomes'. Targets, ADCs, Control, Access.
- Paper prepared by Heather Gifford and Janice Handley, with input from John Mcmenamin and Judith MacDonald. Published July 2007 NZFP 'Primary health care led response to diabetes service delivery'.
- Smoking policy and recommendations

A great deal has been achieved in the last two years, however it is necessary to follow up on several items, to review the objectives of this group and to set goals for the coming year.

These items are listed below:

- NZGG messages put forward as clinical goals and funding allocated for resources to ensure adoption of same chronic care management plan
- Patient held lab forms to prevent duplication
- Advanced form for ADCs: collection of lipid lowering meds information
- Smoking recommendations put forward by Heather (WRS report)
- Education plan: motivational training/methods for health professionals

The Chair of the Diabetes Clinical Governance Group changed at the end of the 2007 year from Janice Handley to Delia Williams.



**WHANGANUI REGIONAL
PRIMARY HEALTH ORGANISATION**

Incorporated as a Charitable Trust under the Charitable Trust Act 1957
Level 1, 76 Guyton Street, P.O. Box 4260, Wanganui
Phone: (06) 348 0109, Fax: (06) 348 8205
Email: wrpho@phi.co.nz

**Whanganui Regional Diabetes Programme Strategy Review
December 2007**

Background:

Whanganui Regional Primary Health Organisation has been the contract holder for the Whanganui Regional Diabetes Programme for the past three years and has just completed negotiation with Whanganui District Health Board for a further three year contract period. The Diabetes Governance Group recognized the necessity to measure the programme's performance to date through an inclusive process with key stakeholders including governance, clinical, consumer and District Health Board participation.

At the November 2007 Diabetes Governance Group meeting a review and evaluation of performance to strategy was undertaken. In August 2006 the contract holder recruited Synergia consulting group to work with the key stakeholders to develop a Wanganui Diabetes strategy. The first phase of the evaluation was to measure progress against the strategy. The second activity was to undertake a SWOT analysis with both Clinical Diabetes Group and Diabetes Governance Group participating.

Progress against Wanganui Diabetes Strategy:

The strategy defines two work streams;

1. Enhancing the Dependability of Diabetes Primary Care in Wanganui
2. Developing an integrated regional plan

1. Enhancing the Dependability of Diabetes Primary Care in Wanganui

Goal	Action	Performance to date
Reducing Diabetes Risk	Increase green prescriptions	Currently not being measured by WRPHO. No formal performance measures or targets in place - practices could be audited or green script could provide stats
	Decrease smoking	No coordinated GP program in place some nurses and GP's have attended smoking cessation training. There are spasmodic programs available. Patches are free but consultations are not funded.
	Increase uptake of health checks	Limited per GP costs for CV risk assessment
	Alignment with HEHA	'Grab a Bite That's Right' coordinator is a member of the Diabetes Governance Group

	<p>Agreed practice policy</p> <p>Increase systematic targeted screening</p> <p>Increase pre-diabetes education</p> <p>Increase use of GPs for health review by Māori and Pacific people</p>	<p>Needs more specific definition in order to have measurable outcomes.</p> <p>Who is measuring this nurse consultations which are included in the PMP are not currently routinely claimed for?</p> <hr/> <p>The Diabetes Governance Group and the District Diabetes Contract have identified that our target population are Māori, PI and low deprivation groups. Targeting of these groups has been successful for diabetes services such as podiatry, which for the 2007 year had a 45% attendance rate of Māori. This targeting has been done through the referral process and clinic locations.</p> <p>Te Oranganui Iwi Health Authority are contracted to provide Kaupapa Māori Diabetes Education to specifically target the Māori population. During the past year this provider has established links with Iwi and coordinates Diabetes Education sessions for Māori in a manner that is culturally suitable</p> <p>WRPHO have provided practices with a list of those Māori and Pasifika patients who are overdue for their free diabetes check</p> <p>At the end of 2006 the Diabetes Education Workshops were revised. All people are welcome however GP's often refer patients with pre-diabetes.</p>
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Goal	Action	Performance to Date
Enhancing diabetes management	Involvement of diabetes educators and pharmacists in practice management	<p>Happens in an informal way but not to any great extent</p> <hr/> <p>The WRPHO Pharmacist Facilitators are actively engaged with practices and contribute to enhancing diabetes management via service delivery. However at grass roots this has tended to be in a reactive as opposed to a planned and proactive way. On the other hand the Pharmacist Facilitator contributes to GP peer group discussions which often function as 'think tanks' for developing ideas that change and shape clinical practice. The Practice Facilitators also contribute to WRPHO clinical governance process which influences practice management as well as maintaining communication networks with practice managers during the course of service delivery.</p>
	Implement practice education – standardized / referrer process and practice liaison support	<p>Is currently under way via Practice Facilitators</p> <hr/> <p>The Pharmacist Facilitators are actively involved in delivering medicines related education via a variety of methods and pathways to practices, clinicians and patients as per service specification.</p>
	Practice increase correct prescribing	<p>A key objective of the Pharmacist Facilitation contract is to promote and increase effective medicines utilisation which includes prescribing by clinicians. This is currently addressed using a variety of methods including:</p> <ul style="list-style-type: none"> - Facilitating individual, local and national feedback on prescribing activity and trends; - Complex medication reviews for individual patients, which include clinical discussion and feedback to the prescriber about the medicines used and related health outcomes of the patient; - Responding to drug information enquiries by prescribers, thereby contributing to dissemination of information about the correct use of medicines; - Production of drug information bulletins to inform prescribers about medicines 'best use' issues. <p>The Pharmacist Facilitator contributes to the WRPHO continuing clinical education programme as well as the WRPHO performance management programme response. The PMP has an increasing focus on clinical indicators incorporating best practice utilisation of medicines with a particular focus on management of diabetes and CVD.</p>
	Increase appropriate self management education	<p>As described above the Pharmacist Facilitators provide complex medication reviews to individual patients. This is a robust service that has been</p>

		<p>provided successfully in the local region since the mid 1990's by two qualified clinical pharmacists. It has been identified that diabetes management could be improved by formally integrating these reviews into the care pathway for diabetes patients. A variety of opportunities and options exist for achieving this objective including;</p> <ul style="list-style-type: none"> - Co-ordinate the complex medication review delivery process with Care Plus, ADCs and other referral pathways that 'capture' diabetes patients - Consider how MUR (Medicines Utilisation Review Services) to be provided by community pharmacists can contribute to improved diabetes management by integration into the diabetes care pathway.
	Integrated pharmaceutical review	All of the above activity needs to be recorded and reported in light of the contribution to the diabetes patients' health outcome, i.e. requires a change in the way PF service delivery is currently reported. In other words 'performance to date' in terms of achieving the actions stated in the strategy is not easily quantified at present due to the way service delivery is captured.
	Integrated education review	By who for who?
	Increased retinopathy	Whanganui DHB has provided WRPHO with resource to pursue methods of increasing the retinopathy checks done as part of the ADC's. To date no significant progress has been made increasing the level of retinopathy screening done.
	Increase Foot examinations	<p>Measured via Leo Brown, this would capture only the free checks not the number who would benefit from podiatrist intervention, don't know number who access private system.</p> <p>Or is this around the foot check within the ADC? In which case the quality of these checks may vary.</p> <p>Podiatry foot care referrals continue to increase which have resulted in the provision of additional podiatry clinics being held to alleviate waiting times. Whanganui DHB has agreed to a slight increase in the level of resource available for podiatry care for the 2007-10 periods. The result of which is that WRPHO can coordinate additional regular clinics to meet patient demand.</p> <p>The level of foot examinations done has increased from 461 checks in the Jan – Dec 2006 period to 504 examinations done in Jan – Dec 2007 period</p>

	Increase ADCs	<p>This year Practice Facilitators are working with practices to try and increase number ADC done but there are already a number of barriers. Wait time at labs for morning fasting blood collects is 1/2-2 hours - no good if you are a diabetic on the way to work. No option for out of work hour's check means many working diabetics never go.</p> <p>The number of ADC's done has increased from 2005-2007:</p> <p>2005 – 1458 checks done 2006 – 1655 checks done 2007 – 1722 checks done</p> <p>Highlighting that since 2005 there have been 264 additional checks done</p>
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While measurable improvement has been variable over the last year much of the work has been to establish resource to facilitate the changes required to systems and 'behind the scenes' processes within primary care. The focus has been on working towards all primary care practices consistently delivering diabetes screening and disease management according to best practice guidelines for the whole population. To achieve this it has necessitated WRPHO to contract three Practice Facilitators, who are senior nurses with clinical, system and process expertise. Another aspect has been to ensure that people are linked to existing disease state management programmes, such as Care Plus, High Needs and Disease State Management services, Whanau Ora programmes and Early Intervention Mental Health service (if co-morbidities exist).

Positive aspects have been achieved to date worthy of noting is the considerable improvement in access to podiatry and diabetes nurse specialist and nurse educators particularly for Māori. Annual Diabetes Checks continue to increase each year however the equity in uptake for Māori remains just out of reach. Pilot projects and strengthening of relationships with Iwi providers are key in improving the health for Māori people with diabetes.

2. Developing and Integrated Regional Plan

Goal	Action	Performance to Date
Lifestyle / Environment	<p>Build sustainability of HEHA</p> <p>Effective parenting / family outcomes</p> <p>Intersectorial collaboration as a norm</p> <p>Improved physical activity / diet</p> <p>Agencies taking responsibility for health</p> <p>Intersectorial plan for reducing obesity (schools / food industry/local government) Increase health promotion schools action</p>	<p>DHB appointed a HEHA Coordinator to integrate projects. Funding ceases for 'Grab a Bite that's Right' initiative July 2008- suggest needs a bit more detail.</p> <p>Intersectorial collaboration evident with Healthy Homes project and Gonville Health project (WRPHO). Comprehensive family assessment occurring for the 50 families engaged in insulation of their homes. Community Garden at Aramoho strengthened with the appointment of a local coordinator to engage community within community development model.</p> <p>Intersectorial collaborative sign off and action achieved for Physical Activity Strategy</p> <p>Māori Community obesity prevention initiatives are to implemented through Māori communities in 2008- funded as an initiative by the Ministry of health</p> <p>PATHS project – implemented</p> <p>Introduction of Nutrition guidelines in schools Fruit in schools project for schools in high need areas</p>
Families and Communities	<p>Stocktake of community activity</p> <p>Building stronger communities</p>	<p>Stocktake of community activities was included in the District Health Board HEHA Plan 2007</p> <p>Stocktake of health promotion and education contracts was undertaken as part of the Ministry of Health process to implement portfolio development in district health boards at an operational level.</p>

	<p>Healthy food at kohanga / early childhood education and in schools</p>	<p>Development of Safer Communities Programme – intersectoral inter agency including councils is under way.</p> <p>District Health Board Tobacco Plan in process of development and sign off from Ministry of Health – support increased smoking cessation programmes and other strategies through primary care providers</p> <p>Increased breast feeding – collaborative approach through HEHA programme</p> <p>Build on closer working relationships: Opportunities to link Māori provider services with primary health services through targeted initiatives such as cervical screening for high risk rural women – build on these to support access to diabetes services</p> <p>Nutrition guidelines for early childhood centres introduced</p>
Health System	<p>DHB and primary care build links with MSD, schools local government for leadership and planning</p> <p>DHB roadmap for chronic care</p> <p>Measures to ensure evaluation</p> <p>Identify children at risk – early intervention</p> <p>PHO / DHB collaboration</p>	<p>Contractual relationship existing with MSD and WRPHO</p> <p>Development of roadmap for chronic care to commence early 2008</p> <p>Introduction of B4 School Check Well child services and Immunisation outreach services Multidisciplinary assessment group – paediatric services implemented</p> <p>Governance and operational - working together – increased</p> <p>Planning process between district health board and primary health organisations increased and improved</p>

	IT system changes to monitor	Information systems – discussions underway between district health board and Whanganui Regional primary health organization
	Rapid response and dissemination of innovation	

The Diabetes Programme has in the main focused on improving diabetes identification and management however, as stated within the strategy it is also essential to increase the focus on the whole system including disease prevention and management of complications. The strategy advises the development of a diabetes prevention plan for the district which has yet to be completed. The second theme of work was to undertake a process review of the management of diabetes complications which includes primary and secondary specialist services. In view of the closer collaborative working between WDHB and the PHOs, it is feasible that this work could be completed in the short term as it fits within the chronic disease framework that is expected to be underway led by the WDHB funder in 2007/2008.

Stronger alignment with lifestyle nutrition and exercise strategies and programmes would also be a priority as prevention of chronic disease is an essential component to a healthy community. Consideration should be given to strengthening the health promotion / population health voice on the Diabetes Governance Group and or Diabetes Clinical Group as a strategy to move the emphasis from assessment / treatment to more focus on population health and wellness.

Evaluation of the Programme Conducted by Diabetes Governance and Diabetes Clinical Group Members:

1. SWOT Analysis

In November 2007 a SWOT analysis process was undertaken that identified strengths, weakness, opportunities and threats of the current programme. The process was inclusive and it was a valuable opportunity to access community, clinician, funder and PHO feedback. The SWOT analysis can be found following this section.

Summary of Key work themes identified:

Workstream	Proposed Actions
1. Appointment scheduling and DNA process requires more flexibility and responsiveness for clients podiatry / specialist nurse / retinopathy and all other clinic services	<ul style="list-style-type: none"> • Identify opportunities for improvement • Explore alternative options for retinal screening that are more accessible for rural consumers • Flexible appointment scheduling process
2. Workforce	<ul style="list-style-type: none"> • Training and education development plan for community health worker group / whanau ora workers / practice nurses and others • Succession planning • Workforce investment plan that is cognizant of changing workforce needs and direction • Self management strategy direction strengthened
3. Integration between Community and GP services	<ul style="list-style-type: none"> • Remove silos • Develop a continuum of care model

4. Community Buy-in	<ul style="list-style-type: none"> • Communication plan and targeted investment • Self management packages – web and paper based and accessible in all communities • Increase community awareness
5. Engage Māori and Pacific Island people	<ul style="list-style-type: none"> • Offer options and choice re access to service • Community strengthened and collaborative approach • Workforce assessments / ADCs where high Māori and PI workforce (take the service to the people)
6. Increase focus on Prevention and Education	<ul style="list-style-type: none"> • Broker low cost exercise options • HEHA engagement strategically and operationally
7. Funding stream for technical clinical advancements	<ul style="list-style-type: none"> • DHB Funding pool established to accommodate Diabetes Insulin Pumps / Bariatric Surgical procedures if considered best practice options
8. Seamless sharing of clinical information	<ul style="list-style-type: none"> • Integrated IT information to support clinical performance and best practice
9. Whanau Mapping	<ul style="list-style-type: none"> • Specific targeted whanau based programmes developing actions and goals to minimize potential of diagnosis and or complications associated to diabetes risk – including lifestyle goals focusing on nutrition and exercise targets
10. Integrated Continuum of care	<ul style="list-style-type: none"> • Move to an inclusive approach considering orthotics/wound management / cardiac management/ nutrition programmes in schools / public policy etc that currently sits outside the diabetes contract programme • Review the diabetes programme contract perimeters to identify those service links that need to be enhanced (see Appendix 2)
11. Nutrition Advise and Resource	<ul style="list-style-type: none"> • Training for community health workers to undertake supermarket tours in all localities • Support attendances at Te Hotu Manawa Māori Nutrition programme (recognized certificated programme) and mentor the trainers to facilitate nutrition education programmes across the region • Develop a comprehensive resource package for effective nutritional advise including training for practice nurses, community health workers and whanau ora workers so consistent nutritional advice and information is delivered across the DHB region

Recommendation:

Whanganui Regional Diabetes Governance Group accept the contents of this strategic document and authorize the progress of the objectives and actions identified within the document and endorse that the workstreams will form the priority for the 2008/2009 period.

Judith MacDonald
 Chair, Whanganui Regional Diabetes Governance Group
 January 2008

Appendix 1:

District Diabetes Service SWOT analysis 21/11/07

Strengths

- Governance and Clinical Decision making
- Collaborative Action
- Whanganui Diabetes Strategic Plan
- Good teamwork between clinicians
- People of various ethnicities involved in programme
- Diabetes Governance interested/informed/positive
- Data shows a difference made with some patients
- Encourages people to be collaborative and lift game
- Untapped pod of resources in practice, e.g. GPs and nurses
- Being more flexible and adapting to government change
- We have a DHB that sees the benefit in a strong primary care approach, e.g. Whanganui was the first in NZ to move contract from secondary to primary care
- Ability to recognize prevention/promotion contribution to community
- Data collection (within contract programme)
- Good working team
- Potentially lots more staff/health professionals involved in diabetes care
- Good networking system between all agencies and people

Weakness

- Training for health professionals and people with diabetes, e.g. care plans, not readily available
- Workload exceeds clinical availability, i.e. travel time, number of patients seen
- Patients who do not receive appointments, i.e. retinopathy are labelled as DNA and are taken off the list
- Information management system (PMS) – not linked across sectors
- Contract specs/funding remains inflexible and not localized to our solutions
- Need ongoing commitment to diabetes strategy across 5-10 years at DHB/Hauora a Iwi level
- Strategic vision not embedded in community or local health sector
- Coordination across the continuum is not consistent
- Potential for presumption that those diagnosed for some years know what they are doing
- Inflexibility of service to appoint at a time that suits the patient, e.g. Podiatry, Retinopathy
- Lack of collaboration – particularly in rural areas e.g. general practice team – Iwi
- Retinopathy clinic in town. Travel barrier for rural patients.
- Lack of buy-in from DHB
- Lack of motivation from some people
- Public awareness is low of diabetes services, communication breakdown
- Limited access to dieticians – only extreme cases qualify to be seen
- We have lots of resources and need to utilise more effectively
- Some people working in silos (not knowing what others are doing)
- Partial interest of services in practices
- Health professionals not talking enough to each other via notes, e.g. Patient accesses a service and then gets called up for an ADC shortly after
- Where do we send people for nutritional support, e.g. weight support/management support
- Need more community health workers to work alongside patient for all aspects of care

Opportunities

- Support (counselling) for newly diagnosed to discuss emotional issues associated with diagnosis, e.g. guilt/depression/fear
- Make people aware of 'big picture'
- To work towards seamless sharing of information
- Avoid retelling patient stories
- Whanau Mapping – Māori as a community have to buy-in
- Other services providing care and been part of primary care setting, e.g. Specialist Nurses – work closer with these services
- Prioritize and focus on key strategies that work – focus on at risk/bite size pieces
- Seek funding commitment 5-10 years
- Involvement of Wanganui District Council in services and planning
- To strengthen a community (regional) approach – inclusive approach
- Develop a seamless integrated service
- To introduce self management/or whanau management/support groups that are sustainable, ongoing and self-determined
- To have nutritional input and involvement at practice/primary care level
- To identify gaps
- To work well together (strength) and achieve more
- Have targeted funding that makes a difference
- Use the talents of people employed by WRPHO and work with GPs, etc
- Go to the freezing works or similar workplaces to offer ADC's and other Diabetes services – make it fun!
- Link diabetes services with mental health
- Mobile service
- Catering for shift workers – evening clinicians
- For WDHB to be further innovative and move diabetes service from secondary services to primary care, e.g. Retinopathy and Dietician
- Link ADC with CVD risk assessment via Bold Promise
- Potential for roles to change with time due to increasing numbers of patients with diabetes – primary care will continue to develop more responsibility of care – Medical Specialists will be restricted to a more complex caseload – so functional role change needs to be accommodated so specialist medical and nursing workforce have non-patient time to develop resources and focus on education and up-skilling of primary workforce.

Threats

- The appointment process/DNA process
- Work Overload
- No clear succession planning for clinical support and leadership
- Non integration of community and general practice services
- Disruption to ongoing funding streams and lack of funds for services, e.g. Podiatry Service
- Clinical demand exceeds workforce capability to manage
- Lack of DHB support – disjointed
- Working in silos across region
- People not listening
- Community buy-in remains low/ill informed
- Māori and Pacific – Requires an increase in the ways to engage at community level
- People with addictive behaviour/negative attitudes and lifelong family habits
- Knowledge and vision of DHB - their ability to understand then work as one voice
- Clinical overload to patient
- Limited focus on prevention and education. Better access to gyms, prescriptions, biking, activities/opportunities

- Acknowledgement of technical advances, i.e. insulin pumps for people with type 1 diabetes - usually cost about \$6,000 - 7,000 per pump and annual consumables \$2000 (no funding is available at present in this DHB)
- Bariatric surgery = \$20,000 approx per procedure - a consideration for patients morbidly obese (package of care needs to be considered) and currently no funding consideration within WDHB

Continuum – Diabetes Programme
 Who's 'in' now – What Should it look like in the future
 Who shares the vision?

