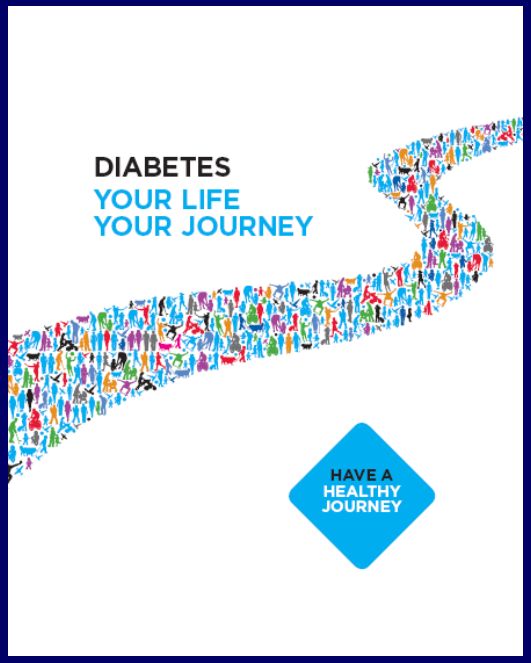
Integrated Diabetes Services between Primary and Secondary Care

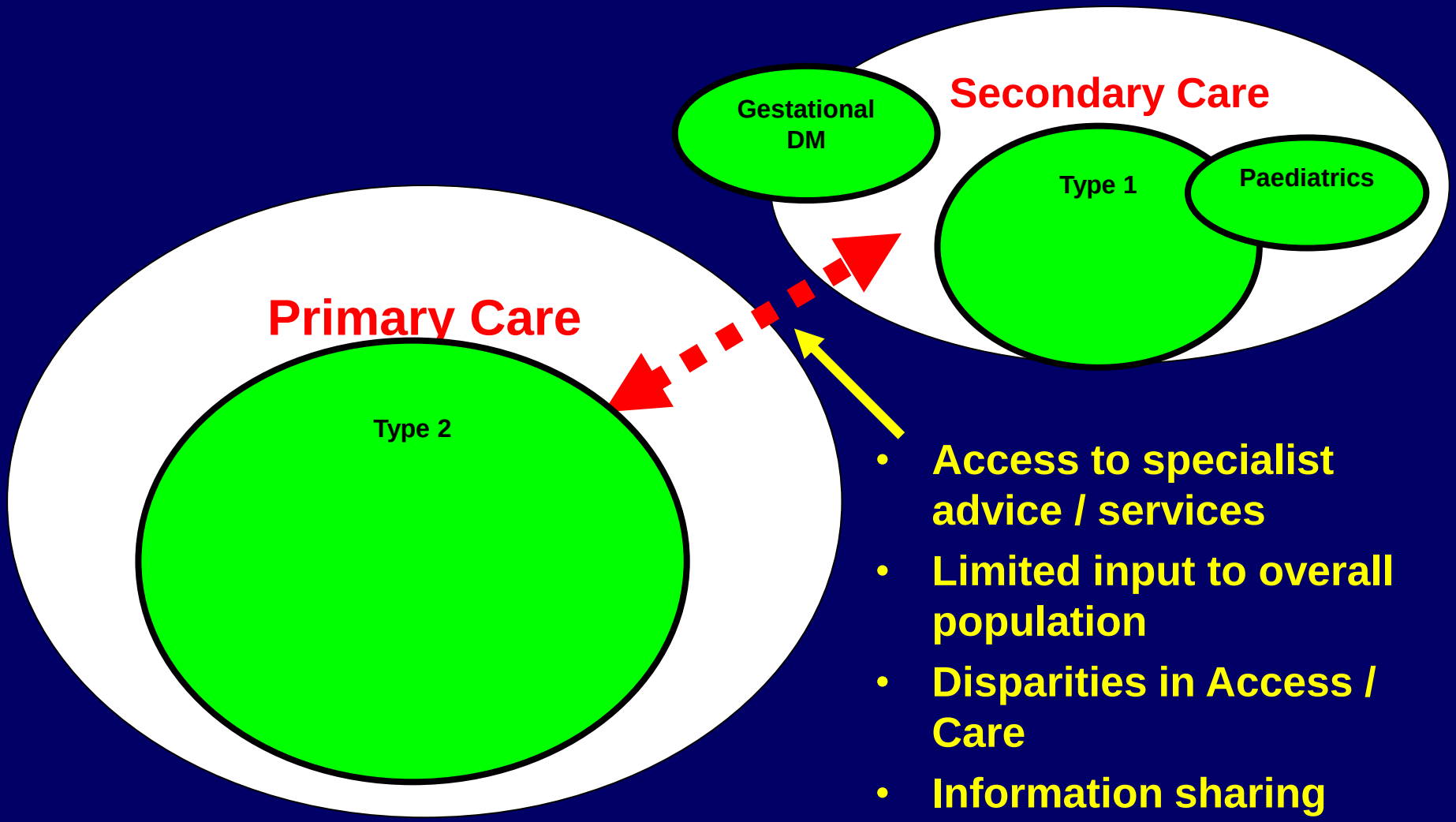


Assoc Prof Jeremy Krebs

Endocrinologist

Capital and Coast Health

Traditional Model of Diabetes Care



- Access to specialist advice / services
- Limited input to overall population
- Disparities in Access / Care
- Information sharing

Issues With Diabetes Care: An Increasing Problem

Primary Care Issues

- Practitioners had sense of ‘isolation’, feeling overwhelmed with growing issue.
- Increasing practice burden.
- Clinical inertia in intervention : medication, insulin
  - It’s not my responsibility – secondary problem.
- Practitioners felt not confident in dealing with much of the chronic and acute diabetes presentations
- Often care opportunistic – when patient presents acutely. Not ‘elective/planned’

Secondary Care Issues

- Only conduit to specialist services through traditional outpatients model
- Issue of Equity: Population not getting equitable access to specialist advice
- Difficult interface between primary and secondary services
  - Who is doing what?
  - Follow up / continuity of care?
- Burden on secondary acute services, acute hospital demand.

Integrated Care Collaborative

- Partnership between Primary and Secondary care
- Clinically driven
- Outcomes focussed

Key Goals

- Get quality services to the population that need it
- Foster patient self management
- Maximise the skills and confidence of the workforce

Diabetes Care Improvement Plan

- Prevent and slow progression of diabetic complications, especially heart disease, renal failure, impaired vision and lower limb amputations
- Reduce disparities between different population groups
- Reduced frequency of diabetes-related presentations to hospital emergency departments
- Reduce rates of hospital admission for diabetes and related complications
- Prevent or delay the onset of diabetes

CCDHB model's key components

- Combined Primary and Secondary Diabetes Clinical Network
  - Performance measures
- Practice population management
- Nurse practice partnership
- Collaborative multidisciplinary outreach activity in priority practices
- Self Management Groups
- Hospital specialist service focused on complex, Type 1, paediatric, gestational and renal diabetes

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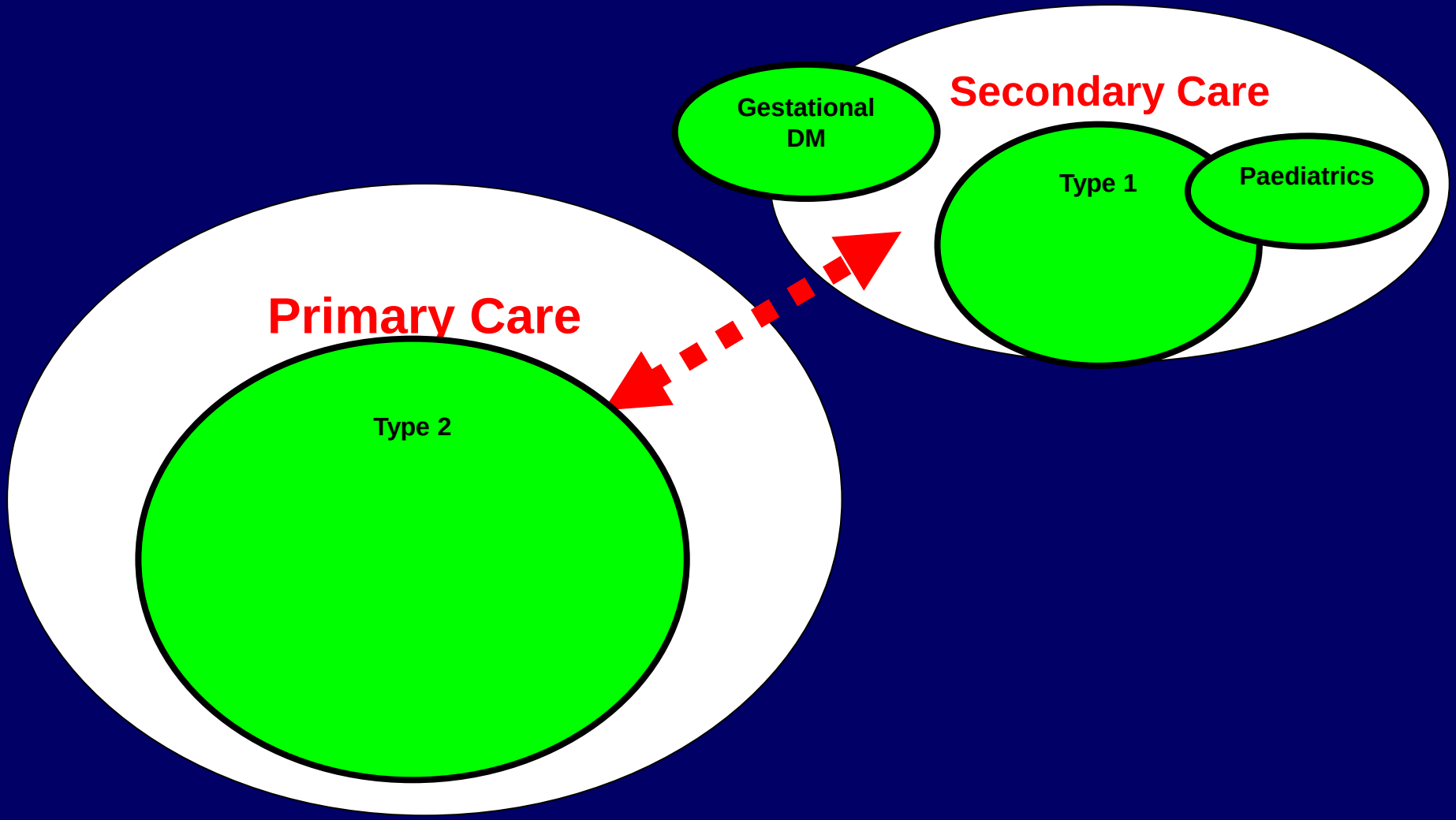

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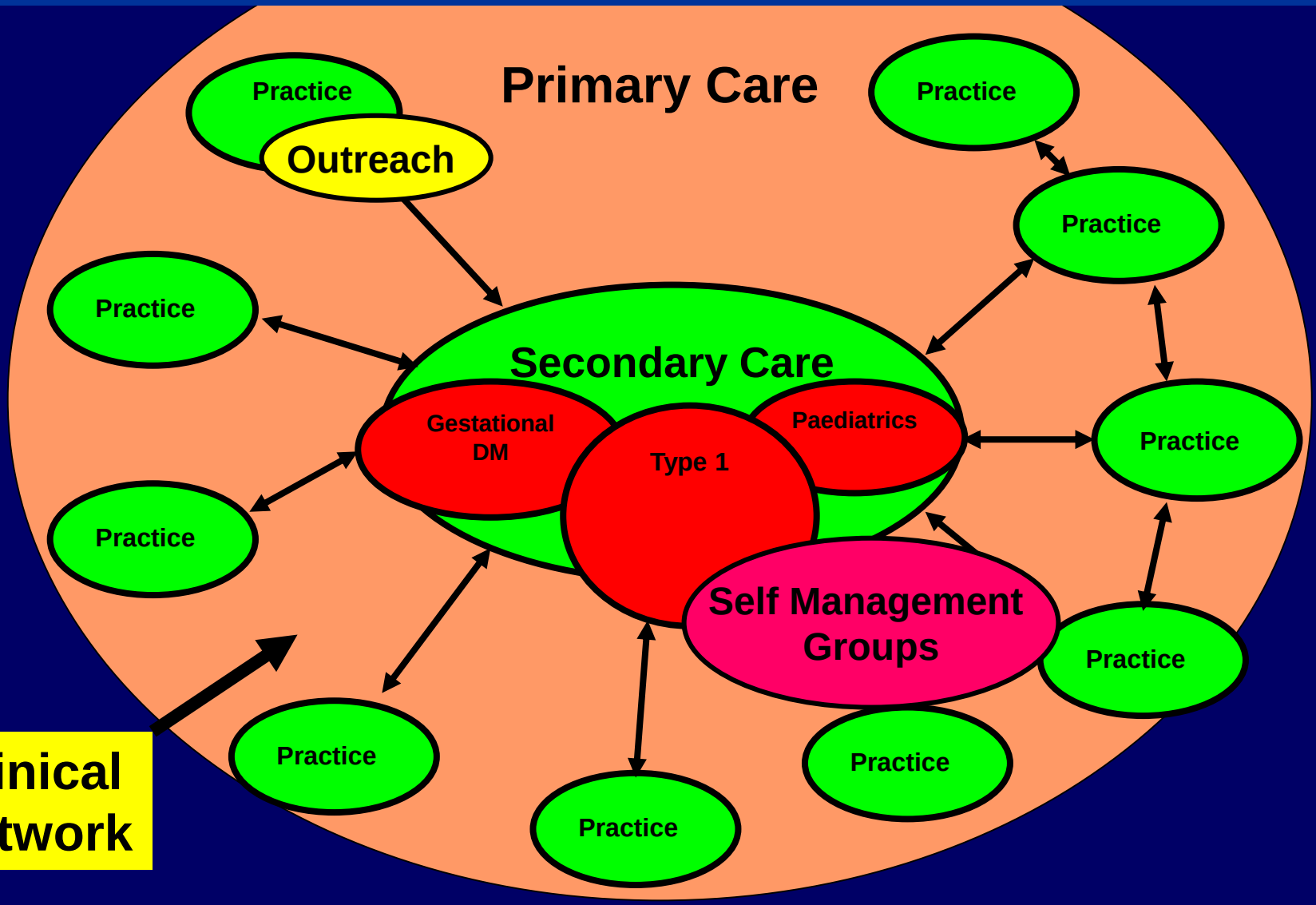
Current Model for Diabetes Management in the Wellington Region



Practice Population Plans

- Flexible bulk funding model
  - Using “get checked” money
- Flexible service delivery
  - Initial assessment & education
  - Management plan targets (lifestyle & medical)
  - Systematic screening for complications
  - Regular long term self management support
- Expectation of a comprehensive annual review
- Aligned to the PPP targets

PHO Performance Plan Targets

- HbA1c > 64mmol/mol not on insulin
- Cardiovascular Risk >15% not on a statin
- BP> 130/80 not on three antihypertensives
- Microalbuminuria not on an ACEI or ARB

Drive Change in Practice

Nurse Practice Partnerships

- 70 practices across CCDHB
  - 15 priority practices
- Nurse aligned to every practice
  - Conduit between primary and secondary care
  - Referrals assigned to relevant nurse
- Virtual team of specialist nurses
- Primary care practice nurses
  - Health mentor on line package
  - Knowledge and skills framework

Nurse Practice Partnerships

- Mix of face to face outreach work
  - Insulin initiation and titration
  - CVD risk management
- Telephone and e-mail support
  - Both nursing and medical

Collaborative multidisciplinary outreach activity in priority practices

- Priority Practices
  - Selected as part of Clinical Network role
  - Based on population, and health disparity

- Specialist services out into primary care
- Multidisciplinary case discussions
- Combined clinics
- Education & peer review

Objectives

- Improve access to specialist skills
  - Population approach
  - Get around DNA effect
  - Provide services and skills closer to patients
- Reduce disparities of access and care
  - Influence care of those not accessing hospital services
- Up skill primary care teams
  - Increase confidence and ability to manage insulin therapy

Porirua Union Community Health Service: Cannons Creek

- Very Low Cost Access Practice, Community Trust: 5000+ popln
  - 55% Pacific, 24% Maori, 7 % European + Refugee
  - 90% Quintile 5
- Complex Patient:
  - Poor Health Literacy, Ischemic Heart Disease, Mental Health, Skin Infection, Rheumatic Fever, English as Second Language
- Twice Acute Hospital Admissions Compared with rest of Capital Coast
- Younger Patient Profile Compared with Rest NZ
- Cost Practice Visits – 0 to $10
- Six Full/Part-time G.P's, seven practice Nurses, Midwives, community worker

The Plan

- Specialist-led case based discussions (Case conferencing)
- Combined integrated interdisciplinary clinics involving high risk patients and their family/whanau/fono, the diabetes specialist and the patient's GP.
- Specialist nurse education sessions for the primary care based nursing team
- Combined specialist nurse and practice nurse patient centred sessions, focused on patient education or insulin initiation or review.

Elements of Case Conferencing

- Primary Care focussed
- Cases sourced by GPs and practice nurses
- Set of criteria
  - HbA1c
  - Complications (eg microalbuminuria in young patients)
  - Recent hospital admission
  - DNA in secondary care clinics
- Inclusive discussion
- Management plans actioned by primary care team

Elements of Combined Clinic

- Primary care led
  - Selection of who is seen
- Joint consultation
  - Both GP and specialist in the room
- Management actioned by primary care team

Outcomes

"The case conferences are an incredibly efficient use of everyone's time. We've been doing this for two years now. When we first started, we'd cover just two or three patients. Now we cover six to eight cases in an hour and although most of these patients don't contact secondary services directly, except in acute situations, we're actually managing to bring specialist advice to them by using this mechanism. It's been hugely beneficial," Dr Betty reflects.

"If we discuss eight cases in an hour together, that also flows on to other patients we see because we just start to manage them differently or we're building capacity within the practice to address these complexities."

"But the other thing was that, as we sat in with Jeremy, we found we needed to refer fewer patients to him as we were learning from what he was doing. Our capability was growing and we realised the real value was in the upskilling that was taking place, and that's where we began to focus on the case conferences together," Dr Gray explains.

Main Learning's

- Efficient use of practitioner time and resource. (increasingly scarce in comparison to demand)
- Time efficient – very important.
- Equitable access to specialist advice key.
- Improved communication and working relationship between practice staff and specialist service.
- Increased confidence practice clinicians in dealing with diabetes issues.
- Feeling of isolation reduced.
- Still issues of what data will show change if any in outcome.

Main Learning's

Other Comments

- Outpatients for chronic disease potentially failed historical model unable to cope with present Type 2 Epidemic.
- Need to challenge way we approach diabetes and think outside square to cope with Type 2 Diabetes Epidemic.
- Primary Care needs to build capacity to deal with issue – can only be done with specialist support.
- Issue is not who should be referred to specialist advice. It is gaining access to right advice at the right time . It is the right practitioner mix – Practice Nurse, G.P., Specialist, Nurse Specialist at the right time. Having the right mix of skills available.
- Often advice or intervention in very Low Cost Access Practise is ‘opportunistic’ not planned elective. Therefore the skill has to be present when the patient presents.
- If we don’t we’re sunk!

Challenges of Model

- Engaging colleagues – Mind shift
  - Both Specialists and GPs
- Funding model
  - Primary care is small business
  - Secondary services funded on PVS
- Ensuring efficiency and added value
  - Travelling is not doing
- Evaluation
  - Does it really make a difference to hard outcomes

Challenges of move to DCIP

- Getting full engagement with all stakeholders
  - Grass roots primary care
  - What about non-priority practices
- Not losing gains made with Get Checked
  - Drop in data collection
- Where do the dollars come from?
  - Get Checked dollars not enough
- Seeing real change in outcomes
  - Assessment drives learning
  - Performance measures drive practice change!

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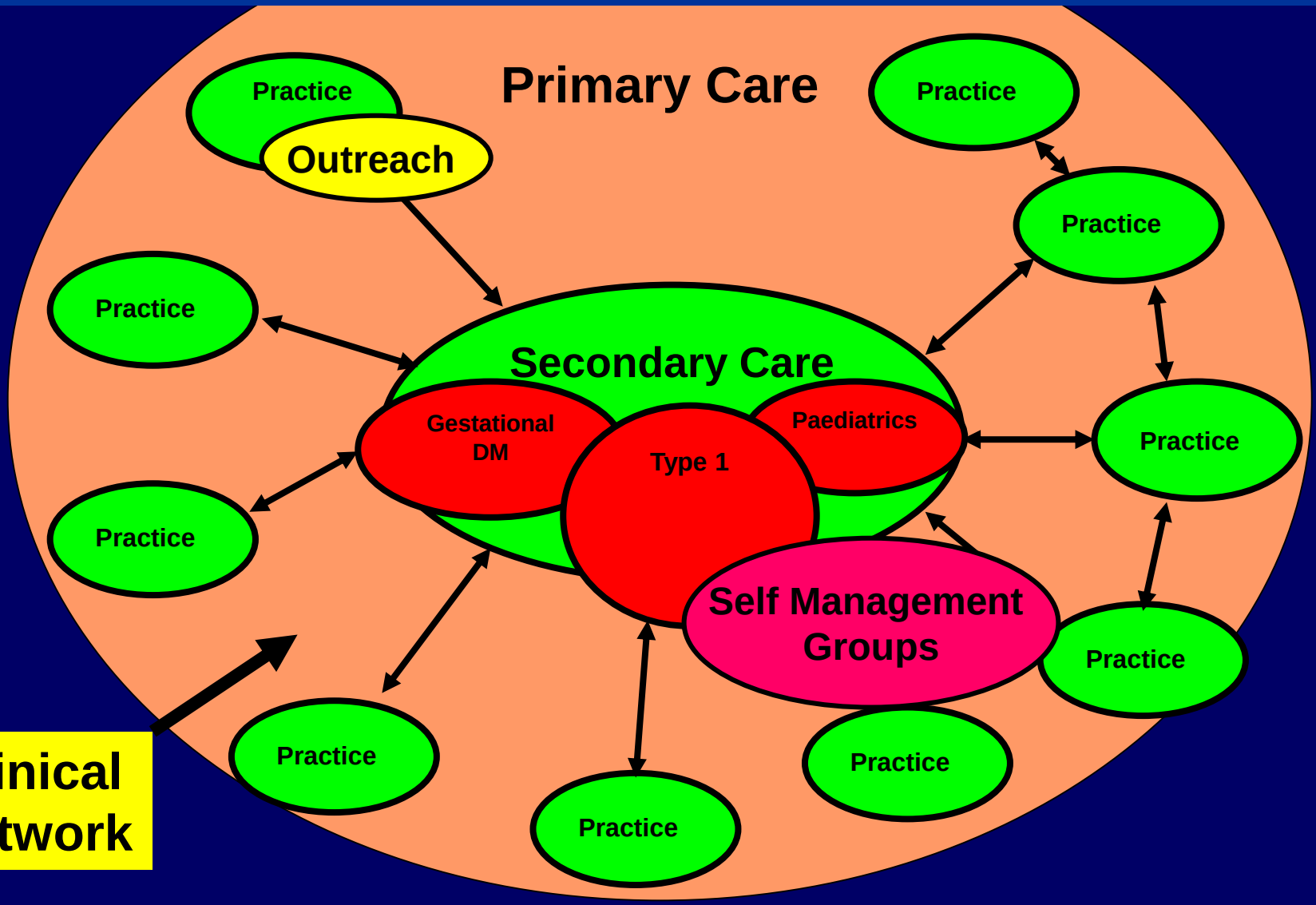

Road to Success

Need

- “Champions”
- Flexibility
- Persistence