The Diabetes Care Collaborative – The South Eastern Sydney Experience

Improving care for patients with Type 2 Diabetes

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Dan Shaw, Manager Innovation SESLHD
A Problem Worth Solving

Figure 2: Type 2 diabetes hospitalisations per 1000,000 population
Breakthrough Collaborative

An improvement method that relies on the spread and adaptation of existing knowledge across multiple settings to accomplish a common aim.
Breakthrough Collaborative

Choose topic

Develop framework & changes

Pre-work

Enrol participants

Expert faculty meeting

LS1

LS2

LS3

Closing Forum

AP1

AP2

AP3

Act
Plan
Study
Do

LS = Learning Set
AP = Action Period

June 2015

Nov 2015

March 2016

August 2016

Dec 2016

NSW Government

Health

South Eastern Sydney Local Health District
Charter and Change Package developed by Expert Faculty Group inclusive of:
- Aim
- Measures
- Driver Diagram
- Change ideas

Change ideas tested by teams
Project Charter

What are we trying to accomplish?

By December 2016, 70% of registered patients with Type 2 Diabetes will have a recorded HbA1c as part of their diabetes management.

How will we know that change is an improvement?

% of active patients with an HbA1c completed within 12 months
% of patients with correctly coded T2DM
% of patients with GPMP’s and TCA’s
% of patients with completed annual cycles of care
% of Service Incentive Payments (SIP)
By December 2016, 70% of active patients with Type 2 Diabetes will have a recorded HbA1c as part of their diabetes management.
<table>
<thead>
<tr>
<th>Change concept</th>
<th>Change idea</th>
<th>Examples to test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardise processes</td>
<td>Standardisation of diagnostic coding for T2DM</td>
<td>• Develop and test cheat sheet and send to all participants</td>
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<tr>
<td></td>
<td></td>
<td>• Explore options for having definitions uploaded onto GP software</td>
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<td></td>
<td></td>
<td>• Audit compliance with diagnostic criteria</td>
</tr>
<tr>
<td>Standardise processes</td>
<td>Refine the diabetes coding process, for accurate capture of numbers of people with diabetes</td>
<td>• Establish an agreed list of codes for diabetes</td>
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<td></td>
<td></td>
<td>• Audit against compliance with use of codes</td>
</tr>
<tr>
<td>Standardise processes</td>
<td>Delineation between active and non-active patients</td>
<td>• Review operational processes for maintaining a current register</td>
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<tr>
<td></td>
<td></td>
<td>• Integrate use of CAT 4 into operational processes for auditing</td>
</tr>
<tr>
<td>Staff training</td>
<td>Training of practice staff in use of software</td>
<td>• Review options for training of practice staff including face to face sessions at practices and group sessions.</td>
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<td>• Develop resources to support practice staff including cheat sheets</td>
</tr>
<tr>
<td>Use automation</td>
<td>Install software tools for notification of missing items</td>
<td>• Ensure software is installed and operational for all practices</td>
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<td></td>
<td>• Train staff in use of TopBar for identification of missing items</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop audit process for identification of missing items</td>
</tr>
<tr>
<td>Optimise measurement</td>
<td>Develop practice auditing process</td>
<td>• Allocate responsibilities for auditing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Train staff in audit process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop cheat sheets for auditing</td>
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<td>• Schedule audit dates to ensure regular monitoring</td>
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</tbody>
</table>
Supporting Collaboration

- Joint practice visits between Primary Health Network and Local Health District staff
- Monthly reports
- Monthly teleconferences
- Phone / Email contact as required
- Linking practices in with services
So where did we end up?
HbA1c Recorded

OCTOBER DATA UNAVAILABLE

Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

2015 2016

NSW Government
South Eastern Sydney Local Health District
CYCLE OF CARE ITEMS

- 20% increase
- 18% increase
- 30% increase

Bar chart showing the comparison of care items between NOV-15 and NOV-16. Items include:
- HBA1C (12 MONTHS)
- EYE EXAM (24 MONTHS)
- BMI (6 MONTHS)
- BMI (6-12 MONTHS)
- BP (6 MONTHS)
- BP (6-12 MONTHS)
- FOOT EXAM (6 MONTHS)
- FOOT EXAM 6-12 MONTHS
- CHOLESTEROL (12 MONTHS)
- TRIGLYCERIDES (12 MONTHS)
- HDL (12 MONTHS)
- MICROALBUMINURIA (12 MONTHS)
- SMOKING
- EGFR (12 MONTHS)

In NOV-16, there is a triple amount of eye exams compared to NOV-15.
Bright Spots

- 4 practices working towards the establishment of nurse led diabetes clinics
- 8 early adopters using newly developed decision support tool – TopBar
- Service redesign new processes developed to standardise care and minimise variation
  - BMI recording
  - Internal benchmarking within multi-GP practice
- Exploring new models for high risk patients such as outreach diabetes clinics
Enablers

- Data support at a practice level
- Supportive leadership within practices
- Shared responsibility within practices
- Consistent support visits and contact
- Data visibility, clear goals
- Networking & relationships
Challenges

- Consistent staffing
- Organisational changes
- Time
- Leading change in larger practices
- Resources
- Governance
Learnings

- Local Health District staff knowledge and understanding of primary care and general practice (& vice versa)
- Amended data report to reflect participation
- Aim too narrow – let teams develop their own aims
- Spelling out expectations with partners
- Too small – needed more participants to build momentum
- Learning Sets refined to meet the needs of attendees
- Assertively follow up reports
- Teleconferences to have an educational focus
- Portal to share and submit electronic reports, information
- General Practices needed formal leadership support and training
- GP Champion in each practice to support culture change
- Time - resource intensive and expensive requires 1.0 FTE Coordinator
- Practices need data support
Mark’s Story

- Solo GP, wife is Practice Manager,
- 1x casual RN

Practice Demographics

- 2,189 patients in total
- 3.17% of patients have a T2DM diagnosis
The Sugar Highs and Lows

MRGP - Hba1c recorded

0.00% 10.00% 20.00% 30.00% 40.00% 50.00% 60.00% 70.00% 80.00% 90.00% 100.00%


72.55% 67.31% 72.73% 80.95% 81.25% 84.62% 80.60% 84.37% 84.37% 85.94% 91.04% 88.41%

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Annual Cycle of Care – November 2015

Count and % of Type 2 Diabetes patients with cycle of care item recorded, filtered by those with a visit recorded in the last 2 years.

Care item recorded in the cycle of care

<table>
<thead>
<tr>
<th>Care Item</th>
<th>Count (%)</th>
<th>% of Type 2 Diabetes patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c (12 mths)</td>
<td>67.3%</td>
<td>67.3%</td>
</tr>
<tr>
<td>Eye Exam (24 mths)</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
<tr>
<td>BMI (6 mths)</td>
<td>55.8%</td>
<td>55.8%</td>
</tr>
<tr>
<td>BMI (6-12 mths)</td>
<td>46.2%</td>
<td>46.2%</td>
</tr>
<tr>
<td>BP (6 mths)</td>
<td>63.5%</td>
<td>63.5%</td>
</tr>
<tr>
<td>BP (6-12 mths)</td>
<td>53.9%</td>
<td>53.9%</td>
</tr>
<tr>
<td>Foot Exam (6 mths)</td>
<td>13.5%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Foot Exam (6-12 mths)</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Cholesterol (12 mths)</td>
<td>61.5%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Triglycerides (12 mths)</td>
<td>59.6%</td>
<td>59.6%</td>
</tr>
<tr>
<td>HDL (12 mths)</td>
<td>57.7%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Microalbuminuria (12 mths)</td>
<td>42.3%</td>
<td>42.3%</td>
</tr>
<tr>
<td>Smoking</td>
<td>98.1%</td>
<td>98.1%</td>
</tr>
<tr>
<td>eGFR (12 mths)</td>
<td>59.6%</td>
<td>59.6%</td>
</tr>
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Annual Cycle of Care – November 2016

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<th>Care item recorded in the cycle of care</th>
<th>MRGP</th>
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<tr>
<td>HbA1c (12 mths)</td>
<td>88.41%</td>
</tr>
<tr>
<td>Eye Exam (24 mths)</td>
<td>92.75%</td>
</tr>
<tr>
<td>BMI (6 mths)</td>
<td>65.22%</td>
</tr>
<tr>
<td>BMI (6-12 mths)</td>
<td>66.67%</td>
</tr>
<tr>
<td>BP (6 mths)</td>
<td>81.16%</td>
</tr>
<tr>
<td>BP (6-12 mths)</td>
<td>81.16%</td>
</tr>
<tr>
<td>Foot Exam (6 mths)</td>
<td>49.28%</td>
</tr>
<tr>
<td>Foot Exam (6-12 mths)</td>
<td>47.83%</td>
</tr>
<tr>
<td>Cholesterol (12 mths)</td>
<td>84.06%</td>
</tr>
<tr>
<td>Triglycerides (12 mths)</td>
<td>84.06%</td>
</tr>
<tr>
<td>HDL (12 mths)</td>
<td>84.06%</td>
</tr>
<tr>
<td>Microalbuminuria (12 mths)</td>
<td>82.61%</td>
</tr>
<tr>
<td>Smoking</td>
<td>100.00%</td>
</tr>
<tr>
<td>eGFR (12 mths)</td>
<td>88.41%</td>
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</tbody>
</table>
“Being a part of the Diabetes Care Collaborative has had a profound impact on the way I work everyday, it has helped me to strive for improvement, provide better care and has provided an understanding of how to turn my ideas into a measurable improvement”.

- Dr Mark Wong, Mulga Road General Practice
Next Steps