



The new face of diabetes care in New Zealand

ON 1 JULY, 2012 the “Get Checked” programme, under which diabetes follow-up care in New Zealand is funded, will cease to exist. In its place will be the “Diabetes Care Improvement Package”.

The Get Checked programme, now over a decade old, entitles people with diabetes to a free annual consultation. The decision to stop the programme was partly influenced by a report by Dr Brandon Orr-Walker for the Ministry of Health, which showed that it produced only marginal improvements for people with diabetes in New Zealand, after ten years and a \$46 million investment. During the Programme, there has been an absolute reduction in HbA_{1c} levels of 1.4 mmol/mol (from the baseline level of 61 mmol/mol), and only two-thirds of patients are regularly accessing their free check-ups.

An audit undertaken by Waitemata District Health Board found that there was no significant difference in the glucose, lipid and blood pressure levels of those patients enrolled in Get Checked compared to those who were not.

The programme’s replacement, the Diabetes Care Improvement Package is “a primary care based programme, building on core diabetes services that are already being provided, to improve outcomes for people with diabetes”. Essentially, the new programme places the coordination of diabetes care in the hands of District Health Boards (DHBs). Rather than a standard national plan, each DHB will have the opportunity to build their own care model based on the New Zealand Diabetes guidelines and their own unique patient population. The funding for the programme will remain at the same level as for “Get Checked”, but it is hoped that the new models will improve the quality, consistency and direction of care for people with diabetes.

At present there is little information on how the new package will affect patients and healthcare providers, as DHBs are yet to finalise and release their individual plans. With that in mind we invited a group of individuals, with expertise in diabetes and health policy, to discuss what they thought was important in diabetes care, what needed to change and whether DHB-led care plans could work in New Zealand.

THE PANEL:

Dr Paul Drury, General Physician and Endocrinologist, Clinical Director, Auckland Diabetes Centre, Medical Director, New Zealand Society for Study of Diabetes. Chair, National Diabetes Services Improvement Group.

Kit Hoeben, Integrated Diabetes Service Manager, Canterbury District Health Board.

Dr Hywel Lloyd, General Practitioner, Chief Medical Officer, BPAC Inc.

Dr Brandon Orr-Walker, Endocrinologist, Clinical Director of Diabetes and Cardiovascular Disease, Ministry of Health.

Dr Tom Robinson, General and Public Health Physician, Waitemata District Health Board.

What the panel said: a summary

The panel agreed that the replacement of the Get Checked programme with the new diabetes care plan has the potential to improve the health of people with diabetes. However, most expressed concern over the potential for fractured care that came from individualised DHB-led programmes. There was consensus that the “ingredients” for a positive change in diabetes care came down to:

- More patient involvement through increased health literacy, health seeking behaviour and self-management of care
- A greater role for nurses in coordination and the delivery of resources
- Greater use of information technology (IT) in order to streamline care and enhance recall, audit and management procedures, especially in primary care
- Involvement of allied care and community care providers, doctors and PHOs in the development phase
- Moving towards a “clinical outcome” rather than “output” basis of measuring quality of care

Can DHB-led programmes improve the quality of diabetes care?

One of the most significant changes with the Diabetes Care Improvement Package is the devolvement from Ministry of Health governance to localised DHB-led schemes. This will allow DHBs to provide services tailored to the specific needs of their local population, which are likely to vary considerably across New Zealand.

The panel agreed that a DHB-led programme could improve on government-led schemes, but only if several criteria could be met in development and implementation:

- A need for local programmes to be tied to national goals, such as earlier identification of at-risk individuals, and better education services
- Adherence to the evidence base, e.g. the 2011 NZGG diabetes guideline
- The involvement of PHOs and community-level providers in the development phase

Working from a foundation of national diabetes priorities and goals is crucial and closely tied to the need to base programmes on interventions and management strategies which are supported by evidence of their effectiveness.

“Twenty unconnected plans won’t do this, local programmes could improve care, but they need to be based on the same overall guidance and goals.” – PAUL DRURY

“There is a very strong evidence base about what works in diabetes management in primary care, so there can be a national system which allows modest regional variation.” – TOM ROBINSON

In terms of the evidence, the Panel agreed that focusing interventions on prevention is key, and will result in long-term savings financially as well as more importantly, reductions in mortality and morbidity. This can come about through earlier identification of people at risk and strenuous application of lifestyle measures before a diagnosis and once the diagnosis of diabetes (or even impaired glucose tolerance) has been made.

“There is growing evidence that lifestyle programmes can drastically reduce the development of diabetes over substantial time frames.” – BRANDON ORR-WALKER

Performance incentives should aim to reduce the key indicators of diabetes health; glucose, blood pressure and lipid levels, rather than just record them. Data should be easy to collect and extract and be made available for analysis and dissemination, to improve and inform health targets.

Community level involvement, i.e. DHBs liaising with care providers on what they require to be able to do their jobs well, is critical to the success of the more localised Diabetes Care Improvement Package.

“I see the Ministry devolving programmes to the DHB level as a good one, so long as the DHBs do the same and

engage with PHOs and enrolled providers to encourage practices to engage in quality improvement. The bottom up approach.” – HYWEL LLOYD

“The ‘individualised’ part, be it at DHB level, PHO level, practice or patient level, needs to acknowledge that in a diverse and vibrant place like New Zealand there may be specific needs, opportunities and challenges that have to be considered beyond providing the core care required by all.” – BRANDON ORR-WALKER

How can the new programme address the disparities in diabetes prevalence?

Māori and Pacific Peoples, people from the Indian sub-continent and people living in lower-decile socioeconomic areas, are disproportionately affected by diabetes and its complications compared to the rest of the population. A PHO Performance Programme Indicator, “Diabetes Follow-Up after Detection”, was implemented during the Get Checked programme to help address this disparity, and will be continuing under the new scheme. The indicator has been successful in increasing the number of “high need” people with diabetes who received an annual review. However, as previously mentioned, it is important that incentives for change focus on improving parameters rather than just recording them. There have been numerous local initiatives within diabetes care that have explicitly targeted high need groups, such as Capital and Coast DHB’s support of the “Pacific Diabetes Fono”, a collaboration that aimed at increasing awareness about diabetes among Pacific people. These initiatives show that focused, community-level schemes can work.

“Great work has shown that these differences can be eliminated, e.g. glycaemic control in Māori in Manaia PHO, so the sector needs to be aspirational, just like has occurred with smoking cessation and immunisation coverage.” – BRANDON ORR-WALKER

The Panel agreed that districts with the greatest proportion of high need patients would need larger allocations of funding in order to address disparities. Two main themes emerged for how to use this funding to best target high need patient groups:

- Increased community and patient engagement, thereby increasing health literacy
- Better use of information technology to manage patients

“We need more community buy-in to self-care and we need to raise people’s expectations, though different ethnicities and communities will need different approaches.” – PAUL DRURY

“[We need] greater use of allied care providers, greater resources in the community and an increase in participation and engagement with focus on self-management.” – KIT HOEBEN

“Active systematic recall and follow up is one of the few mainstream things that is shown to reduce inequalities.” – TOM ROBINSON

While the path to eliminating disparities may not be completely clear, DHB-led programmes have the advantage as they allow for more community-level involvement in the planning and implementation stages of programme development. It comes back to the “bottom up approach” and the consensus seems to be that, without engagement from the groups at the greatest risk, with the greatest need, it may be difficult to derive much additional benefit from scrapping Get Checked and starting again.

What are the major factors that contribute to quality diabetes healthcare?

The cessation of the Get Checked programme came about in part because it was not delivering clinically significant health benefits to people with diabetes. In 2009 the Office of the Auditor General surveyed General Practitioners on their views and experiences of the Get Checked programme. General Practitioners felt that the programme was not improving diabetes healthcare, because:

- The funding did not cover the costs of delivering the checks or completing documentation
- They saw the check as an information-collecting exercise
- A higher proportion of people failed to attend the pre-arranged appointment than failed to attend for acute complaints (indicating that greater freedom to work opportunistically might be beneficial to healthcare providers)

These lessons need to serve as the basis for the Diabetes Care Improvement Package.

Funding is likely to always be an issue with diabetes care, and the number of people with the disease is growing rapidly. Several members of the Panel felt that a way to maintain quality of care, while operating within funding pressure, was to have patients with diabetes increasingly managed by nurses with specific expertise in diabetes care. Another way to address funding issues is to provide community-level care in a group setting. This needs to focus on giving people with diabetes a greater understanding of their condition, the tools

to change the progression of their condition and a sense of control and achievement when things go well.

“[We’ll see a change in the] amount of care that will be provided by other members of the general practice team, i.e. nursing and pharmacy.” – KIT HOEBEN

“[We need] increased activity from the people providing appropriate advice. This is more about community leadership, and is particularly relevant for high risk ethnicities and circumstances (e.g. where medical care is less available) in the areas of prevention, modification of lifestyle, positive role modelling, and support.” – BRANDON ORR-WALKER

“Patients will be involved to a much greater extent in self-management support. [They need] a greater sense of engagement and participation.” – HYWEL LLOYD

In order to avoid the Diabetes Care Improvement Package becoming an information collecting exercise, the focus needs to change from collecting the information to applying the information.

“This is all about the clinical culture. Entering a patient into a ‘subscription’ to receive something won’t achieve anything on its own. But if that is used to ‘make space’ for the care of diabetes in a proactive way that can catalyse improved care then the result will be a return on investment with better health and less cost.” – BRANDON ORR-WALKER

“Quality is not an end point or a destination but a process of implementing a programme of care that facilitates everyone involved to ask themselves collectively: Are we doing the right things? Are we doing things right? Do we have the capacity to improve?” – HYWEL LLOYD

The Diabetes Care Package needs flexibility in its application, to allow for diabetes detection and follow up to occur at any health encounter. This is particularly important for patients who attend general practice infrequently and who, in the past, have failed to attend scheduled “Get Checked” appointments.

How will care change from a patient perspective?

The goal of the Diabetes Care Improvement Package is to improve the quality of care that each person in New Zealand with diabetes receives. Within the constraints of current funding, it is likely that patients will begin to see less of General Practitioners and more of nurses and other healthcare providers. The intensity of care will be based on their disease progression. For example, a patient with diabetic neuropathy on insulin may receive free quarterly consultations with

the practice nurse, whereas a patient without diabetic complications may be seen only annually by their General Practitioner. While this has already been the case in certain PHOs under the Get Checked programme, for many patients this will represent a significant change.

Group education and more community involvement may also be new for some people with diabetes.

“More intense care where it is required. Normal community care where it isn’t.” – TOM ROBINSON

“Those with greatest need will be targeted and receive more frequent support than is delivered currently. There will be a growing interest in group participation programmes where care can be offered to a larger group with less specialised resources.” – HYWEL LLOYD

What are the potential stumbling blocks?

The Panel identified several areas where either more work, a greater commitment from organisational bodies or a different approach to care will be needed.

“The current workload of general practice teams means there isn’t going to be ‘space’ or time to extend their activities unless there is an investment in service redesign, which would likely mean new staff and physical space.” – KIT HOEBEN

As the new programme will retain the same overall level of funding as Get Checked, this is likely to be the major barrier and determinant of the level and type of services that can be offered to patients.

“[There is a current] lack of clinical expertise/time in primary care... and unhelpful funding models; many practices are simply overwhelmed.” – PAUL DRURY

“Long-term condition care still does not receive the resources that it deserves.” – TOM ROBINSON

“Our health funding, and health workforce is unlikely to expand at the same rate [as diabetes is], so to even maintain a [static] level of care we will have to provide care in new ways.” – BRANDON ORR-WALKER

Whatever the stumbling blocks may be, the Diabetes Care Improvement Package offers the opportunity to refocus the way diabetes is managed in New Zealand away from process-based model to a care-based model that is individualised to unique, local patient populations.

Watch this space

We await with interest the look of the new Diabetes Care Improvement Packages as they are rolled out by DHBs. There may be drastic changes that alter the face of diabetes care in New Zealand, or, it may simply be a re-branding of the same old plan. There is a wealth of information and research available, and considerable input has gone into reviewing what worked and did not work under the old scheme. It is hoped that local planners will incorporate some of the ideas outlined here by the Panel, when they implement the Diabetes Care Improvement Package. Finalised DHB annual plans will be published on individual DHB websites in the coming weeks, and should contain programme directions and specific information.

 For further information on funding, development and requirements of the Diabetes Care Package, visit: www.health.govt.nz

The views expressed here are those of the individuals and do not represent the views of the organisations that they work for or represent. All views are of an opinion nature and are not necessarily indicative of how the Diabetes Care Improvement Package will be run as individual plans are yet to be finalised.

The New Zealand Formulary

COMING SOON

NZF

One of the early deliverables for the NZF is an online interactions checker.

For a sneak preview, visit: www.nzformulary.org

Have a go and tell us what you think!

New Zealand Formulary interactions checker

Enter a medicine and select from the drop-down list. Add medicines one at a time to build your search. Refer to key for action category, and hover over text for explanation of severity and evidence.

warfarin sodium ▾ Eruen ▾

Choose from
 generic
 brand

Currently the interactions checker is provided for demonstration and evaluation purposes only.
Search terms are taken from the NZ Medicines Terminology. Many medicines are now known by potentially unfamiliar names.
Full synonym support will be provided in future releases of the interactions checker.
Herbal medicines and foods, including grapefruit juice, will be added soon.

Medicines	Explanation	Action	Severity	Evidence
warfarin (systemic) and ibuprofen (systemic)	Ibuprofen does not alter the anticoagulant effect of warfarin or other coumarins. However, NSAIDs reduce platelet aggregation and can therefore prolong bleeding: one study in patients taking warfarin showed that ibuprofen prolonged bleeding times and microscopic haematuria and haematomata were seen in some patients. Isolated cases have been reported of a raised INR and/or bleeding with concurrent use.	 Avoid NSAIDs if simple analgesics are adequate or in those at a high risk of bleeding (e.g. those with a history of NSAID-induced ulcers). If concurrent use is necessary be aware of the potential risks of bleeding. Consider giving gastroprotection (such as a proton pump inhibitor).	Severe	Formal study