

Canterbury

District Health Board

Te Poari Hauora o Waitaha

**Disease Prevention and
Management:
CDHB Diabetes Actions
2004/05**

December 2004

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Executive Summary

As part of Diabetes as a Strategic Priority, here is the next list of actions, timeframes and and outcomes. These will be reviewed again in 2005, once the Local Diabetes Team 2004 Annual Report is complete. In most cases work is underway.

The table below gives a summary of the actions and the funding and timeframes associated with them.

Summary of Actions

Action	Funding	Timeframe
1 Diabetes prevention and monitoring		
1.1 Continued disease prevention and promotion efforts		
✓ Continue to promote the importance of having an annual check	Cost neutral	Ongoing
✓ Work with identified providers for healthy eating and physical activity programmes to ensure diabetes retains an appropriate profile	Nil	Ongoing
✓ Identify opportunities to work alongside cardiovascular plan initiatives	Nil	Ongoing
1.2 Provide access to community podiatry services for patients with “uncomplicated” high risk feet		
✓ This will be achieved by increasing community access by funding 1 visit per annum with a community based podiatrist (estimate 1,200 patients) for each patient with “uncomplicated” high risk feet	1,200 visits @ \$40 = \$48,000 (must be sustainable)	Implementation to begin in the New Year 2005 through an RFP process
1.3 Improved patient management of diabetes through the provision of education and support to patients, families/whanau and care providers		
Patients, their families/whanau		
✓ Contract with primary care organisations to provide diabetes-specific group education programmes relating to lifestyle (diet, exercise and footcare) for patients and their families/whānau. Target delivery alongside existing community initiatives (provided by Community & Public Health and Diabetes Life Education for example) and include patients with history of gestational diabetes. Lifestyle Advisers being piloted for 12months	\$72,000 pa	
✓ Investigate the feasibility of implementing the Stanford Chronic Disease Self-management programme ¹ , possibly together with other services		

¹ The aim of this programme is to support self-management of chronic diseases. The New Zealand Arthritis Foundation currently promote this programme to people with arthritis.

<p>(eg. cardiovascular, respiratory, pain clinic)</p> <p>Workforce</p> <ul style="list-style-type: none"> ✓ Disseminate management of type 2 diabetes guidelines to all general practices ✓ Utilise secondary care expertise to provide updates for primary care teams regarding management and referral (especially podiatry and retinal screening) ✓ Support implementation of cardiovascular disease guidelines for GPs ✓ Encourage providers to undertake the Level 7 paper in diabetes offered by CPIT ✓ Support the development of the Community Support Worker role targeting the Māori and Pacific peoples populations to support and facilitate access to treatment and education for consumers/family/whanau ✓ Liaise with CPIT to develop a Level 4 paper for caregivers, resthome staff, community workers and lay people. 		<p>Completed by the NZGG with Ministry of Health funding</p>
<p>2 Retinal Screening</p>		
<p>2.1 Provide access to retinal screening in the community</p> <ul style="list-style-type: none"> ✓ Continue to improve access to retinal screening 	<p>This work is part of the Review of the Eye Department</p>	<p>Ongoing</p>
<p>3 Actions to improve the system of care</p>		
<p>3.1 Secondary care</p> <p>To ensure that people with diabetes admitted to other areas of Christchurch Hospital, and those caring for them, receive specialist advice. To achieve this will require:</p> <ul style="list-style-type: none"> ✓ An increase in nurse specialist time to support patients admitted to 'other' inpatient services at <u>all</u> hospitals and liaise with primary care on discharge ✓ The establishment of a discharge pathway for follow-up education in general practice ✓ Consideration of providing follow-up appointments in the community. (Extending rural clinics to the city will address access issues and current Diabetes Centre facilities issues). The Local Diabetes Team will discuss this and make a recommendation ✓ Providing opportunities for diabetes specialists and general practitioners to work together at centre or practice 	<p>Currently being piloted in Wards 23,24 and the Emergency Observation Area; needs extra resource to cover other wards</p> <p>Ultimately work to free up resources so a nurse specialist 1.0FTE @ \$70,000</p>	

<p>3.2 Accuracy of information</p> <p>Work to make sure that local database information is robust and complete:</p> <ul style="list-style-type: none"> ✓ Ensure that annual review data from secondary care is provided to the local databases 	Cost of data entry person	Work underway to determine hours required
<p>3.3 Integration</p>		
<p>Identify and utilise opportunities to work co-operatively with other relevant initiatives, especially those relating to cardiovascular disease</p> <ul style="list-style-type: none"> ✓ Ensure the involvement of advisory/steering groups from other plans in the development of any initiatives that may be of mutual benefit, recognising that responsibilities need to be clearly defined ✓ Investigate further the sectorisation of district nurses with diabetes expertise to improve the liaison between people with diabetes, the Diabetes Centre and primary care 	Nil	

The Annual Objectives for Diabetes in the District Annual Plan are:

- Combined action on diabetes and cardiovascular disease and cancer in conjunction with NZGG Guidelines
- Increased understanding of diabetes and self management for Māori and Pacific peoples
- Enhanced services for children and youth with diabetes

The Outcomes for the Actions summarised above are described fully in Section 5 on page 12 below and fit within the District Annual Plan framework.

1. Introduction

1.1 Background

The vision of the Canterbury District Health Board (Canterbury DHB) is “To improve the health and wellbeing of people living in Canterbury”. The Canterbury DHB’s Strategic Plan sets out the values and ways in which we will work to achieve this vision and the directions to move forward. ‘To reduce the incidence and impact of diabetes’ is one of the New Zealand Health Strategy’s and the Canterbury DHB’s priority health objectives, as it represents a severe and growing health problem in our population.

The prevalence of diabetes and the risk factors for diabetes are similar for cancer and cardiovascular disease and both are especially prevalent in Maori and Pacific peoples populations. There is concern about child and adult obesity leading to early onset of type II diabetes. Rates of type I diabetes have increased fivefold over the last 25 years.

Key issues relating to diabetes are:

- Diabetes often goes undetected for a long time – on average someone may have diabetes for seven years before it is diagnosed and may incur much damage to their body during that time;
- It is a chronic disease and if poorly controlled, serious complications can result.
- In turn, these complications require costly treatments. With increasing numbers of people with diabetes in our community there will be an increased need for treatments such as dialysis, putting additional pressure on resources such as skilled staff, space, equipment and so on.
- Many people with diabetes end up with ongoing disabilities such as blindness and/or amputation, which affect their daily living and quality of life.
- The significant impact of diabetes on Māori and Pacific peoples and the prevalence of the disease among them.

In October 2002 the CDHB Board adopted an interim plan for diabetes service development. This plan made a number of recommendations, which have been implemented. These recommendations can be found in section 2. The Interim Diabetes Plan provides useful background information on diabetes and service provision and is available on request.

The 2004 Diabetes Action Plan updates progress on recommendations made in the 2002 plan and proposes further areas for effort in the next few years. These areas were identified and suggested through the Local Diabetes Team (LDT) annual report development process and expanded at a Canterbury Diabetes Steering Group meeting held in July 2003.

The Canterbury Diabetes Steering Group (DSG) was recommended and established as part of the implementation of the interim plan and is comprised of members of the LDT and experts in specific areas of diabetes management. Terms of reference for the LDT are attached as Appendix 1

The LDT/DSG believe the Actions within this plan will reduce the rate of increase in the prevalence and incidence of diabetes in Canterbury. This plan will be reviewed annually and the outcomes reported in the LDT Annual report.

1.2 Local Diabetes Team

The Local Diabetes Team is comprised of representatives of all sectors working with diabetes including health promotion/prevention workers, Maori and Pacific health providers, primary and secondary care services. A list of the organisations represented within the LDT is attached as Appendix 2.

Service components within the LDT service specification are:

- To provide representation from each of the major diabetes healthcare stakeholders in the area.
- To undertake information analysis and an advisory role to the DHB
- To prepare and submit the Annual Report which provides indicators on:
 - Diabetes case detection rate
 - Diabetes case management
 - Retinal screening of people with diabetes in the last two years
 - Implementation of the Diabetes Minimum Data set based on information within the regional database.

1.3 Addressing inequities

This Plan has been developed within the context of other CDHB plans, such as plans for Māori, Pacific peoples and Primary Care. This is so plans to improve the health and wellbeing of our community are consistent and actions are coordinated.

Over the past few years, considerable effort has gone into putting measures in place, particularly in primary care, to provide the basis for improving Māori health status. Implementing measures such as improving the collection of ethnicity, coding diseases and implementing disease management plans means the Canterbury DHB is beginning to have a better picture of current Māori health status.

Feedback from current initiatives and Māori and Pacific communities continues to reinforce the need to provide services in a way that is acceptable and accessible to these communities, ie. targeted and provided in a location/facility that is appropriate. Barriers to access include cost, transport and lack of cultural responsiveness among mainstream staff and providers. This will continue to be considered during the delivery of Actions within this plan.

1.4 Integration with other initiatives

As many studies have shown there is a strong link between diabetes prevention and nutrition and physical activity. Implementation planning for 'Healthy Action: Healthy Eating', the Ministry of Health's Integrated Strategy for Physical Activity, Nutrition and Healthy Weight, is underway. This strategy recognises the need for intersectoral action with a range of approaches based on the Ottawa Charter. Any efforts made as part of the implementation of the diabetes plan need to be carefully considered and implemented to avoid duplication of services/initiatives.

Clear linkages exist between diabetes and cardiovascular disease and actions defined in each of these plans will impact on the efforts of the other. Regular communication to identify opportunities for collaboration will occur during implementation of this plan.

2. Current plan status and activity in Canterbury

2.1 Previous recommendations:

The following table outlines progress to date (as at September 2004) against the recommendations made in the Diabetes Interim Plan 2002 and the Local Diabetes Team Annual Report 2002.

Recommendation	Status
Establish a Diabetes Steering Group	Completed
Retinal screening - additional volumes) - additional eye treatments) - review Retinal screening	Hospital and Specialist Service contract increased Completed – awaiting implementation
Increase community podiatry	Pilot programme complete
Additional 0.2 FTE Māori nurse in Diabetes Centre	Completed
Support health promotion activity which focuses on disease prevention and health education.	MoH contract awarded to implement the community nutrition programme Support is ongoing
Continue and evaluate the Māori and Pacific peoples Leadership pilot	Evaluation completed. Work currently underway by P&F and C&PH to refocus service.
Improve quality and completeness of annual review information ethnicity data collection	Ongoing – monitoring of data integrity
Shared care	Progressing
Implement system to improve connections between specialties	Progressing – report under development identifying people admitted with a diagnosis of diabetes - this is currently being piloted
Child and Youth health plans incorporate plans for health promotion, and services for children and youth with diabetes	Completed
Establish a Diabetic Registrar position	Completed – registrar position confirmed for a 2 year period
Support Local Diabetes Team	Ongoing – P & F membership of LDT
Provide education in care of the diabetic foot to upskill interested community podiatrists	Project completed
Fund visit for patients with high risk feet with community	Project completed

based podiatrist	
Increased nurse specialist time to support patients with diabetes who are admitted to “other” inpatient services at all hospitals and liaise with primary care on discharge	Underway in Wards 23, 24 and Emergency Observation Area
Provision of new building for Diabetes Centre	Work in progress

2.2 Additional activities:

In addition:

- Additional resource has been provided to the diabetes team based at Ashburton Hospital (Podiatry and Dietitian).
- The number of gestational diabetes clinics has been increased at Christchurch Women’s Hospital.

2.3 Other issues/activities:

2.3.1

The Local Diabetes Team has surveyed patients with diabetes who attend annual reviews to determine their response to this initiative. The majority of respondents (86%) had either had a check in 2003 or were planning to have one. However 6% of respondents were unaware they were able to have a free annual check.

2.3.2

The Local Diabetes Team received three applications for funding specific projects:

- Provide a one-hour staff teaching session on general diabetes in 30 resthomes at a cost of \$3,900. Funding for this has been agreed.
- Investigate the best way for the Diabetes Centre to provide diabetes education to its patients; specifically whether it should provide group education, and if so to whom. This proposal has been agreed and funding of \$9,600 has been allocated.
- Initiate a diabetes screening programme in two general practices for non-Europeans to find people with undiagnosed diabetes or those who have not had a fasting glucose test in the past three years. This proposal has been agreed and funding of \$1,300 has been allocated.

3. Diabetes service contracts

The Canterbury DHB spends both directly and indirectly on diabetes. The table below sets out the known current contracts relating to health funded diabetes services in the Canterbury DHB's district. In addition to the direct spending shown below, indirect spending occurs when people are admitted as a consequence of diabetes complications, such as lower limb amputation or kidney failure.

Other organisations, such as the Lions and the National Heart Foundation, work in other areas associated with diabetes. We do not have the information to quantify this work. These groups work co-operatively with others such as Community and Public Health, LDT, diabetologists and primary care practitioners to supplement health services for people with diabetes.

Provider	Service
Nurse Maude Association	Diabetes community nursing services – 1.4 FTE
Diabetes Christchurch Inc	Local Diabetes Team: Review, monitor and evaluate diabetes services
Community and Public Health	Diabetes health strategy for Māori and Pacific people: Leadership and Community Development Programme (Lifestyle advisers)
Christchurch Hospital Division	First attendance
	Subsequent attendance
	Diabetes education and management – Youth education, Māori and Pacific peoples liaison
	Nurse/non-medical clinics – Podiatry, Nurse educators, Dietitians
	4 rural outreach clinics in North Canterbury – a number of different venues rotated over 3 years
	Retinal screening
	Insulin pumps for patients with type 1 diabetes
	Psychologist to assist people (especially adolescents) with issues related to diabetes – 1FTE
Women's Health Division	First attendance
Women's Health Division	Subsequent attendance
Ashburton Hospital	Diabetes education and management
Community and Public Health	Diabetes Life Education: Diabetes early detection and prevention service
Otautahi Māori Women's Welfare League	Chronic disease management of diabetes
Pegasus Health	Diabetes, Asthma and Cardiovascular disease management (one-off payment)
	Contract holder for Diabetes Annual Reviews (fee for service), co-ordination with other annual review providers.
Southlink Health	Contract holder for Diabetes Annual Reviews (fee for service), co-ordination with other annual review providers. Training and management
Hurunui Kaikoura Rural Health	Diabetes management services
Papanui Medical Centre	Diabetes management services

4. Priorities

The diabetes sector has suggested that the following principles should underlie any service development process. They have been used initially to identify areas where extra resources in diabetes services should be placed and/or reviews undertaken:

- Sustainability over the planning horizon;
- Best value for money;
- Commitment to increased volumes to cope with existing and future flow-on effects.

The principles listed above have been taken into account when determining the Actions below. Action on the priorities is aligned with the Core Directions of the Canterbury DHB, which are:

- Improving the health status of our community;
- Finding better ways of working;
- Working together;
- Developing our health workforce; and
- Being a leader in hospital and health care services.

Input into the development of Actions for this plan has come from the Local Diabetes Team Annual Report (2003) and a workshop held by the Canterbury Diabetes Steering Group held July 2003. Excerpts from these documents are attached as Appendix 3

In the Annual Report the LDT is required to set targets for national indicators determined by the Ministry of Health. These targets are reviewed annually and relate to:

- Diabetes detection: *What proportion of people with diabetes are getting annual checks and the associated high quality of primary care in our District Health board population?*
- Diabetes Management: *What proportion of people with diabetes have relatively poor control of their diabetes?*
- Diabetes Management: *What proportion of people with diabetes have had their eyes screened in the last two years?*

Implementing the Actions below will work towards achieving the targets set and hence will improve the health status of this group of the Canterbury DHB's population.

5. Actions

These Actions have been aligned with the Ministry of Health's national indicators as described above.

The development of services for people with diabetes along with prevention efforts will continue to occur alongside work on Cardiovascular disease and Cancer. We need also to keep in mind the work being done on the Community and Primary Health Strategy knowing that that plan may affect the way services are delivered in the future.

5.1 Diabetes prevention and monitoring: *What proportion of people with diabetes are getting annual checks and the associated high quality of primary care in our District Health board population?*

5.1.1 Disease prevention and health promotion

Desired outcome:

Continued disease prevention and health promotion efforts.

- The LDT has undertaken a survey to determine the proportion of people with diabetes who continue to have their second and subsequent annual checks, including biennial retinal screening. The results of this survey were included in the 2003 Annual Report.
- Promote the importance of having an annual check among people with diabetes, their families/whānau and primary care providers
- Work with identified providers for healthy eating and physical activity programmes to ensure that diabetes retains an appropriate profile
- Identify opportunities to work alongside cardiovascular plan initiatives

Estimated cost: Cost neutral

5.2 Diabetes management: *What proportion of people with diabetes have relatively poor control of their diabetes?*

5.2.1 Podiatry

Desired outcome:

Patients with “uncomplicated” high-risk feet have access to community podiatry services

This will be achieved by:

- Increasing community access by funding 1 visit per annum with a community based podiatrist (estimate 1,200 patients) for each patient with “uncomplicated” high risk feet
- This will be implemented in the New Year, 2005, through an RFP process with one or two providers.

Estimated cost:

1,200 visits @ \$40 = \$48,000 (must be sustainable)

5.2.2 Education

Desired outcome:

Improved patient management of diabetes through the provision of education and support to patients, families/whanau and care providers.

Feedback from the Māori and Pacific communities indicates that the best approach to reaching Māori and Pacific peoples is to use Whanau and Community Health Workers and Māori and Pacific providers providing them with the education and training to enable patients to access the right services at the right time.

Patients, their families/whanau

- Contract with primary care organisations to provide diabetes-specific group education programmes relating to lifestyle (diet, exercise and footcare) for patients and their families/whānau. Target delivery alongside existing community initiatives (provided by Community & Public Health and Diabetes Life Education for example) and include patients with history of gestational diabetes. Lifestyle Advisers being piloted for 12months
- Investigate the feasibility of implementing the Stanford Chronic Disease Self-management programme², possibly together with other services (eg. cardiovascular, respiratory, pain clinic)
(<http://patienteducation.stanford.edu/programmes/>)

Workforce

- Disseminate management of type 2 diabetes guidelines to all general practices
- Utilise secondary care expertise to provide updates for primary care teams regarding management and referral (especially podiatry and retinal screening)
- Support implementation of cardiovascular disease guidelines for GPs
- Encourage providers to undertake the Level 7 paper in diabetes offered by CPIT
- Support the development of the Community Support Worker role targeting the Māori and Pacific peoples populations to support and facilitate access to treatment and education for consumers/family/whanau
- Liaise with CPIT as they develop a Level 4 paper for caregivers, resthome staff, community workers and lay people.

Estimated cost: Lifestyle Advisers \$72,000pa

² The aim of this programme is to support self-management of chronic diseases. The New Zealand Arthritis Foundation currently promote this programme to people with arthritis.

5.3 Diabetes Management:

What proportion of people with diabetes have had their eyes screened in the last two years?

5.3.1 Retinal Screening

Desired outcome:

Provide access to retinal screening in the community.

- This will be achieved by continuing to implement the recommendations of the retinal screening review.

Estimated cost:

As per the costs stated in the retinal screening review paper

5.4 Actions to improve the system of care

5.4.1 Secondary Care

Desired outcome:

Patients with diabetes admitted to other areas of the hospital (and those caring for them) receive specialist advice.

To achieve this will require:

- An increase in nurse specialist time to support patients admitted to 'other' inpatient services at all hospitals and liaise with primary care on discharge. This was put in place in August 2003 in Wards 23, 24 and the Emergency Observation Area but more resource is required to cover other wards
- The establishment of a discharge pathway for follow-up education in general practice
- Consideration of providing follow-up appointments in the community. (Extending rural clinics to the city will address access issues and current Diabetes Centre facilities issues.) The Local Diabetes Team will discuss this and make a recommendation.
- Providing opportunities for diabetes specialists and general practitioners to work together at Centre or practice.

Estimated costs:

Ultimately work to free up resources for nurse specialist: - 1.0 FTE @ \$70 000 (must be sustainable)

5.4.2 Accuracy of information

Desired outcome:

Local database information is robust and complete.

- Ensure that annual review data from secondary care is provided to the local databases

Estimated cost:

Cost of data entry person. Work underway to determine number of hours required per week. Ongoing administration to be determined.

5.4.3 Integration

Desired outcome:

Opportunities to work cooperatively with other relevant initiatives are identified and utilised.

- Ensure the involvement of advisory/steering groups from other plans in the development of any initiatives that may be of mutual benefit, recognising that responsibilities be clearly defined.
- Investigate further the sectorisation of district nurses with diabetes expertise to improve the liaison between people with diabetes, the Diabetes Centre and primary care

Estimated cost: Nil