

CCM – Chronic Care Management  
LTC – Long Term Conditions

### DIABETES ACTION PLAN (C&C DHB)

The table below indicates activity intentions, using a systematic approach based on Wagner’s CCM Model (1999) adapted for C&CDHB.

*(Funding Dependant)*

Activity	Community Including: Community resources and policies	Health System Including Patient safety	Self Management Support	Delivery System Design Including; Cultural competence Care Coordination Case management	Decisions Support and Clinical Information Systems	Timeframe
Planning Evaluation Information	<p>Promote consumer agency involvement in planning through Local diabetes Team + DHB /PHO communications Support &amp; strengthen:</p> <ul style="list-style-type: none"> <li>- Diabetes Wellington</li> <li>- Diabetes Kapiti Inc.</li> <li>- Regional Paediatric</li> <li>- Diabetes Group</li> <li>- Pacific Diabetes Group</li> <li>- Whanau Support groups in Wellington &amp; Porirua</li> </ul> <p>Identify existing services and</p>	<p>Maintain diabetes as a priority in DHB across whole system including: Population health, primary care, secondary care &amp; support services</p>	<p>Care Plus//Hand Held Records and other mechanisms to improve self/whanau management</p>	<p>Improve access to primary care and other services</p> <p>Ensure appropriate information is available</p>	<p>Use Ministry of Health Diabetes Model and Get Checked data to monitor progress with DHB, PHO, providers</p> <p>Increase access to Electronic health record and use of Care Plus/Hand Held Records</p> <p>Improve access to Software for decisions support through MOH Key Directions project</p> <p>Continue to improve</p>	2008-10

	<b>networks available for dissemination of information</b>				<b>regular feedback to practices and practitioners</b>	
		<p>Use District Plans, Health Needs Assessment (DHB), PHO plans, PHO performance framework, monitoring reports, reviews and evaluation &amp;- Impact of diabetes investment to inform planning &amp; prioritise diabetes work</p> <p>Ensure District Plans &amp; PHO plans include diabetes + LTC as a priority</p>		<p>Offer workforce development opportunities re diabetes: clinical + culturally competent care</p>	<p>MOH, DHB, PHO, providers data for monitoring access + progress.</p> <p>Ethnicity to include Asian &amp; sub categories</p>	2008-10
		<p>Monitor access of high risk groups + outcomes for high risk groups in health system</p>	<p>Update Service directory for people at risk of or with diabetes every 2 years</p>	<p>Source &amp; distribute resources in appropriate languages &amp; formats</p>	<p>Improve access to primary care &amp; other services for Maori, Pacific, low income populations &amp; other groups at higher risk of diabetes</p>	2008/09
		<p>Establish joint primary/secondary clinical interface governance structure</p>				By June 2008

		<b>Health Needs Assessment (DHB) to include PHO input re diabetes + co-morbidity information</b>		<b>Ensure referral processes are agreed and in place (primary &amp; secondary endorsement) through GP liaison + primary/ secondary interface governance group</b>		<b>Oct 2008</b>
			<b>Evaluate different supports, resources, services, formats to identify key gaps in information and support for people with diabetes</b>			<b>By Oct 2008</b>
		<b>Distribute reviews and evaluation - Impact of diabetes investment, Annual Get checked performance, other relevant information to whole sector</b>				<b>6 monthly report</b>
		<b>Implement New Service Specifications as appropriate</b>				<b>2008-10</b>
<b>Prevention Primary and Secondary</b>		<b>Joint primary/secondary clinical interface governance structure</b>				<b>By June 2008</b>

		<b>in place</b>				
	<p><b>Continue to promote healthy eating, healthy action (HEHA) through measures to increase:</b></p> <ul style="list-style-type: none"> <li>- Food security</li> <li>- Access to good nutrition</li> <li>- Promoting physical activity</li> <li>- Using multi-level approach involving agencies , NGOs, Iwi, different settings (workplaces, schools, churches), PHOs, Communities</li> </ul> <p><b>Diabetes awareness Week</b></p>	<p><b>Increase access to appropriate resources – nutrition, physical activity, medication, and psychological support for people with diabetes</b></p> <p><b>Support routine screening for ‘At risk’ groups in general practice and optimal use of Annual Checks and appropriate services through workforce development</b></p>	<p><b>Increase resources, peer support groups, services and access to information, early advice to prevent the development of diabetes or delay the onset</b></p> <p><b>Increase access to affordable recreation and physical activity, income to support good nutrition for people living with diabetes</b></p> <p><b>Support Public policy &amp; action (eg. Work with MSD, Local Govt) to support prevention, for eg: supportive environments, income and employment, healthy affordable housing, smokefree environments, healthy school environments, urban planning</b></p>	<p><b>Joint planning with Public health services and input into public policy that supports prevention of diabetes</b></p> <p><b>Increase access to primary care through design elements that reduce barriers &amp; increase access for people at high risk of or with diabetes</b></p>	<p><b>Distribute evidence to inform interventions eg:</b></p> <ul style="list-style-type: none"> <li>- Social indicators report.</li> <li>- Public Health Intelligence &amp; MOH information</li> <li>- Academic publications of relevance.</li> </ul> <p><b>Regular feedback to practices and practitioners</b></p>	<b>2008-10</b>
				<b>Support Maori development and</b>		<b>Implement Te Plan II</b>

				<p>intersectoral support for healthy Maori communities</p> <p>Support and opportunities for populations at risk of diabetes including: low income populations, Maori, Pacific, Indian</p> <p>Increase uptake of Annual checks particularly by Maori</p>		2007 - 2012
			Develop & distribute consumer friendly information sources and support –for individuals, families, different populations	Culturally appropriate information and services. (Pacific, Maori, Asian, Other ethnic groups, youth, older people)		By Dec 2008
Early identification		Joint primary/secondary clinical interface governance structure in place				By June 2008
	<p>Raise awareness in Community of:</p> <p>Availability of screening programmes</p> <p>Screening opportunities and</p>			<p>Diabetes detection – service design to increase opportunistic screening and annual checks</p> <p>Identification and optimal management</p>	<p>- Analysis disaggregated by age, ethnicity, gender, NZ Dep and where possible TLA</p> <p>- Data re utilisation at primary care level</p>	2008-10

	<p>available information in multiple community settings and multiple languages</p>			<p>of gestational diabetes and pre conceptual counselling</p> <p>Improve diabetes screening &amp; management for mental health consumers, Asian &amp; sub populations</p> <p>Increase referral for diagnostics and support timely affordable access.</p> <p>Links with CVD plan</p>	<ul style="list-style-type: none"> <li>- Screening coverage data</li> <li>- Trends in diabetes detection and control</li> <li>- Trends in diabetes complications - comorbidity</li> </ul> <p>Regular feedback to practices and practitioners</p>	
				<p>Increase referral for diagnostics and timely, affordable access. Links with CVD plan</p>	<p>Monitor through:</p> <ul style="list-style-type: none"> <li>- Analysis disaggregated by age, ethnicity, gender, NZ Dep and where possible TLA</li> <li>- Data re utilisation at primary care level</li> <li>- Screening coverage data</li> <li>- Trends in diabetes detection and control</li> <li>- Trends in diabetes complications - comorbidity</li> </ul>	2008-10

<b>Optimal Treatment &amp; Management</b>		<b>Establish joint primary/secondary clinical interface governance structure</b>				<b>By June 2008</b>
					<b>Explore decision making tools + software for supporting clinical decisions.</b>	<b>By June 2009</b>
		<b>Support structured primary care for people with diabetes and comorbidity</b>		<b>Increase access to primary care</b>	<b>Diabetes Get checked 2/+CVR Risk Assessment Tool + agreed referral criteria into to secondary care</b>	<b>By June 2009</b>
				<b>Increase access to podiatry</b>		<b>By 2010</b>
				<b>Expand retinal screening to ensure increased % coverage</b> <b>Reduction in disparity against baseline 2007/08</b>		<b>By 2010</b>
			<b>Continue to support child &amp; youth camps and other tailored diabetes education and support for children, youth and</b>			<b>By June 2010</b>

			families			
	Work with Regional Paediatric Group + Diabetes Youth Wellington (DYW) to look at ways school support for young people with diabetes could be improved			Clinical pathway established for people with CVD + diabetes across HHS & primary care – trial with high needs consumers to improve case management		By June 2009
	Consumer information sources about optimal care, care options, service options.	<p>Support evidence based practice through workforce development opportunities &amp; practice audits</p> <p>Feedback from secondary care to primary care &amp; vice versa</p>	Increase understanding & support across entire health and community sector of support for individuals and families living with diabetes to enable optimal self/whanau management	Continued development, implementation and monitoring of clinical pathways and guidelines	Ensure mechanisms for shared consumer information	By June 2010 Regular feedback to practices and practitioners
	Improve access to information and affordable primary care Improve access to Diagnostic interventions, laboratory services, specialist consultation, specialist nurses and		Resource allocation that recognises the importance of prevention and as a key focus of health service delivery	Audits, clinical governance	2008-10	

		<p>specialist allied health</p> <p>Access to appropriate resources – nutrition, physical activity, rehabilitation, psychological support, family/whanau support</p> <p>Disability support aids and equipment</p> <p>Resources and systems to reduce adverse events in hospital and primary care</p> <p>Smoking cessation support</p>				
<p>Equity</p> <p>Reducing disparities</p>	<p>Work with Wellington Local Diabetes Team to continue focus on reducing disparities</p>	<p>Work with joint primary/secondary clinical interface governance structure in place to focus on equity of access + outcomes</p>				<p>By Oct 2008</p>
		<p>Acute care pathways and multidisciplinary guidelines – endorsed by both primary and</p>			<p>Regular feedback to practices and practitioners in variable formats.</p>	<p>2008-10</p>

		<b>secondary - implement for Maori with diabetes and CVD</b>				
	<p>Reduce impact of diabetes for Maori population through specific investment</p> <p>Support for self/whanau management through supportive, enabling communities including access to income, to ensure access to all treatment options</p> <p>Develop marketing approach for a Maori audience that promotes well health and longer life</p>	<p>Promote accessible primary care for Maori, Maori provider development &amp; responsiveness of all PHOs to Maori</p>	<p>Support innovative Whanau models of care</p>	<p>Trial assertive treatment programme for Maori at risk by combining clinical treatment models, socio-behavioural models and action research</p> <p>Maori workforce development in diabetes –specialist nurses (Maori) , Maori community/whanau support workers upskilled in CCM</p> <p>Links with CV navigation projects and action research</p>	<p>Monitor access and outcomes by age, ethnicity as in Te Plan II</p>	<p>Ongoing 2008-10</p> <p>+</p> <p>Implement Te Plan II</p>
	<p>Reduce impact of diabetes for Pacific populations through specific investment</p> <p>Work with Pacific Diabetes Wellington Society, Diabetes Kapiti Inc, Wellington Local Diabetes Team,</p>	<p>Promote Pacific led primary care and access to primary care for all Pacific people</p>		<p>Develop linkages through Pacific service in hospital with diabetes programmes in community</p> <p>Continue to develop Pacific specific approaches to</p>		<p>Ongoing 2008-10</p> <p>+</p> <p>PSAP</p>

	PHOs			reducing diabetes incidence and impact		
	Community participation to inform design. Mechanisms for consumer and community input			Access to services across entire health system increased for high need populations	Monitoring of access and outcomes by age, gender, ethnicity, NZDep where feasible  Public Health Intelligence/Ministry of Health information.  PHO and DHB level analysis and monitoring tools  Identification processes in place for other populations and groups	2008-10
Workforce	Public health workforce  Health promotion capacity in PHOs, working with communities & intersectorally	Establish Primary / secondary clinical interface governance structure  Support GPs and nurses with a special interest within practices  Support upskilling, support resthomes and other residential settings	Workforce development in support for self/whanau management  Support for consumer groups, peer-led support  Support training for workforce including structured consumer self-management training & whanau	Support primary care-general practitioners, nurses, allied health  Community support workers, link workers, interpreters to work as effective multidisciplinary teams. Time for CCM type of care, case review - Secondary care		Ongoing 2008-10  By June 2008 establish primary/secondary interface governance group  Workshops Courses Specialist outreach

		<b>Build capacity in child and youth service areas</b>	<b>needs increase specialist outreach, child and youth workforce development</b>	<b>Consultants Specialist Nurses Diagnostic capacity Support increased skill in primary care to carryout insulin starts</b>		
		<b>Support access to secondary care Consultants Specialist Nurses Diagnostic capacity. Appropriate use through GP liaison, primary &amp; secondary nurse and clinical governance</b>	<b>Ensure workforce training in cultural competence, clinical care, self/whanau management</b>	<b>Upskill &amp; develop capacity in current providers Workforce with ability and willingness to work across a variety of settings</b>	<b>Appropriate decision support information. Feedback to practitioners and teams of relevant information, audit, review through PHO clinical governance groups, 6 monthly DHB progress reports and other reviews</b>	<b>By June 2009</b>

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**Medium term outcomes**

**Increased % people Annual Check**  
**Increased Care Plus uptake**  
**Increased % Retinal Screening uptake**  
**Increase those with HbA1c < 8%**  
**Reduced smoking rates**  
**Reduced obesity**  
**Increased physical activity**  
**Increased flu immunizations**  
**Reduced avoidable hospital admissions**  
**Early diagnosis and screening**

**Reduced diabetes complications:**  
**(amputations, blindness , renal failure etc..)**

**Reduced cardiovascular disease (strokes, heart attacks etc..)**

**Improved quality of life**

**Reduced mortality**

**Reduced disparities in diabetes outcomes**

**Increased % of people participating in:**  
**Regular physical activity**  
**self/whanau management**  
**weight control strategies**

**Behaviour changes in both people with diabetes, their whanau and providers.**

**Policy, environmental & system changes.**

