MINISTRY OF HEALTH
MANATŪ HAUORA

The Diabetes Update

A bi-monthly newsletter introducing new people, projects and progress in the world of diabetes health

No. 5 November 2015

Welcome to the fifth issue of *The Diabetes Update*. The newsletter tells you about the national direction for diabetes, the work programme and shares innovative stories from around New Zealand.

Please feel free to share the newsletter far and wide. If you would like to receive an email when each new issue is released, or if you want to share a story in the newsletter, email cvddiabetes@moh.govt.nz putting 'subscribe me' in the subject line.

Launch of *Living Well with Diabetes*

The Minister of Health, Hon Dr Jonathan Coleman, launched *Living Well with Diabetes 2015–2020: a health care plan for people at high risk of or living with diabetes* on 16 October 2015. The launch was hosted by Counties Manukau DHB and we would like to thank the staff for all their support. It was a really successful event.

Following consultation with the sector the final plan was revised to six priority areas.

- Priority 1 – prevent high-risk people from developing type 2 diabetes
- Priority 2 – detect diabetes early and reduce the risk of complications
- Priority 3 – enable effective self-management
- Priority 4 – provide integrated and coordinated care
- Priority 5 – improve quality services
- Priority 6 – meet the needs of children and adults with type 1 diabetes.

The Ministry will work with DHBs on how the priorities in the plan can be implemented. Work is already under way through DHB annual plan commitments for 2015/16. Keep an eye on this newsletter for more information on the implementation of the plan.

The full plan can be found on our website: www.health.govt.nz/publication/living-well-diabetes

New Zealand Health Strategy consultation

The Ministry is currently consulting on the draft update of the New Zealand Health Strategy from 27 October to 4 December 2015.

Your feedback is important and will ensure we create a truly unified way forward.

Consultation is open to any person or organisation interested in contributing to the future of New Zealand's health and disability system.

All information on the consultation is available on the Ministry website:
www.health.govt.nz/publication/new-zealand-health-strategy-consultation

Manawanui Whai Ora Kaitiaki

In early 2014, the Ministry of Health tendered for a demonstration project for a new model of care for patients living with long-term conditions. This model of care would focus on empowering people living with a chronic disease to successfully self-manage or share-care their condition.

Healthcare New Zealand approached Hauraki PHO to partner in submitting a proposal for such a model of care. It was agreed that should the proposal be successful, the navigator position would be added to Hauraki PHO's proposed outreach nurse model in the demonstration sites.

The service is called Manawanui Whai Ora Kaitiaki which, loosely translated, means Guardians of wellbeing.

The model is a community based integrated care service that facilitates a web of interdisciplinary care around the patient (and family) over a time limited intervention phase of 3 to 6 months.

This model is strongly anchored to a philosophy of improving patient self-management and whānau ora principles. Whānau ora concepts take a holistic view of what the patient identifies as their social and health priorities, and the self-management model supports patient activation and shared decision making. Both concepts are reflected in the shared care patient plan.

Erica Amon, Area Manager for Healthcare NZ believes that an important differentiator of this service is the navigator position (kaiawhina) working closely with a registered nurse (case manager), who partner with the patient to meet their needs by providing navigation and coordination functions.

This service is being independently evaluated at the moment, but both staff and patient feedback suggests this model is successfully supporting patient empowerment.

Lindsey Webber, Clinical Services Manager, Hauraki PHO shared some of the staff feedback.

- 'Patients lead the way – care plan goals are set and owned by patients making them meaningful and more likely achievable.'
- 'Patients are empowered to better manage their condition – doors are opened for them and introductions are made to help build reliable support networks around people.'
- 'It's great knowing that we have helped a family to get stronger; not only physically but in spirit and emotionally too.'

Patient comments have also given some insight to the value of empowerment.

- 'Without this service I wouldn't have got to get a look at things I needed to do. The nurse and kaiawhina explained things in words I understand at my pace.'

- ‘We feel supported and assurance is only a phone call away – it’s a form of security as this is all new to me. I was really well up until 2 years ago.’
- ‘It was so good to have someone to turn to while working through this stressful health episode.’

Implementing Chronic Kidney Disease Consensus Statement

Best Practice Advocacy Centre Incorporated has been contracted by the Ministry of Health to develop and provide an electronic decision support tool for general practices for the management of chronic kidney disease.

The decision support tool is a web-based application that integrates with primary health care practice management systems and provides up-to-date clinical support for patient management. The tool automatically calculates the stage of chronic kidney disease, one and five year rates of decline in eGFR, and the age at which a patient is predicted to enter stage 4 chronic kidney disease.

The tool provides best practice management advice to support patients with chronic kidney disease. Referral recommendations to secondary care services are based on the national chronic kidney disease consensus statement, UK NICE guidance and the National Kidney Foundation KDOQI clinical practice guideline for diabetes and chronic kidney disease.

There is ongoing work with stakeholders to ensure tool’s referral criteria is aligned with the national chronic kidney disease consensus statement and that there is local resource availability. Once regional pathways have been agreed, the tool will be made available to general practitioners throughout New Zealand and integrated into electronic referral pathways where possible.

Dr Tom on a mission

The Ministry’s CVD/Diabetes and Long Term Conditions team has contracted with the Health Innovation Centre (HIC) to work with the Healthy Families New Zealand communities to improve healthy attitudes, raise awareness of the risks of long-term conditions, such as diabetes and reconnect people with primary health care.

HIC’s commitment to the prevention kaupapa includes engaging Dr Tom Mulholland. He will work with the Healthy Families communities to improve attitudes in health care to long-term conditions like diabetes, cardiovascular disease and encouraging people to become smoke-free.

The HIC is also working with Barbara Docherty, who has extensive experience in Training and Development Services (TADS) training, and Atlantis Healthcare to help deliver training of health professionals and adherence of patients to the agreed behavioural change.

Thanks for reading. We look forward to keeping you in touch.

On behalf of the Diabetes Team at the Ministry of Health:
Sam Kemp-Milham, Vicky Shuker, Dr Paul Drury and Dr Helen Rodenburg.

Feedback/suggestions to: cvddiabetes@moh.govt.nz