

The Diabetes Update

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

No. 8 February 2017

New Zealand Government

Welcome to the eighth issue of *The Diabetes Update*. This newsletter includes diabetes-related updates from the Ministry of Health (the Ministry) and information on progress in implementing the diabetes plan Living Well with Diabetes and shares innovative stories from around New Zealand.

Please feel free to share this newsletter with your contacts. 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 with 'subscribe me' in the subject line.

Pre-diabetes and self-management advice

The Ministry recently released advice on pre-diabetes and self-management of long-term conditions on its website. This includes evidence-based advice on pre-diabetes risk factor management for health providers. It also includes a summary of findings and implementation advice based on a small number of pilot projects on pre-diabetes and self-management approaches. Both documents can be found at: health.govt.nz/our-work/diseases-and-conditions/diabetes/about-diabetes/pre-diabetes-and-self-management-long-term-conditions

Weight management programme for people at risk of diabetes or CVD

Compass Health have recently partnered with Weight Watchers to provide a weight management programme targeting adults at high risk of developing diabetes or cardiovascular disease. The aim is to link GPs and patients to an established commercial or community weight-loss provider not traditionally regarded as a referral partner.



Programme outline

Compass Health recruited and provided training to 14 general practices, prioritising those with the highest numbers of patients who meet the high-risk criteria (HbA1c of 41–49 mmol/mol and a BMI of 30–40). Letters were then sent from practices to eligible patients, providing detailed information on the programme and inviting patients to take part. Five hundred patients were invited by their GPs to participate, and recruitment is now complete with 207 patients enrolled on a Weight Watchers programme. →

Living Well with Diabetes – A plan for people at high risk of or living with diabetes 2015–2020



These patients receive, free of charge:

- an initial assessment with a practice staff member (usually a practice nurse) covering information on: pre-diabetes; ways to reduce the risk of developing diabetes; physical activity; and how to access low-cost exercise options in the Wellington area. Baseline measurements (including HbA1c) are also collected
- Weight Watchers membership for three or six months (six months if recruited in July), which is delivered online by phone or in groups
- two follow-up appointments three and six months after completion of the Weight Watchers membership to review the baseline measurements.



Key points

- The programme is led by general practice/primary health care.
- There are 135 people (65 percent) on the six-month programme, with the remainder on the three-month membership.
- Most people are participating in the group programme, which previous studies have shown to be the most effective way to lose weight and maintain weight loss.
- Compared with the 'typical' Weight Watchers member, who is a woman in her 40s, the study cohort is older (in their 50s or 60s) and includes a higher proportion of men (40 percent).
- There is a higher proportion of Māori and Pacific participation than is present in the Compass Health patient population – 17 percent Māori and 16 percent Pacific participation compared with 10 percent Māori and 4 percent Pacific people in the Compass Health population as a whole.

Early results

- Some substantial weight losses have been recorded, with losses of up to 24 kg since July 2016. Weight loss percentages are currently highest in the male participants.
- Practices report that although the programme has been time consuming, it has provided an opportunity to form relationships with a group of people who are not usually seen in their practices. This has enabled other screening to be completed and has provided an opportunity to have a pro-active discussion around illness prevention.
- Discussions with participants show that even when people cannot attend Weight Watchers meetings, they are still making some changes to their lifestyle that may impact on their future health. These changes will also be reflected in the post-programme evaluation.

The programme will be evaluated by the University of Otago. The evaluation will measure the efficacy and cost effectiveness of using a dedicated weight management programme in association with primary health care to support at-risk people. In late 2017, the Ministry's diabetes team will share key findings of this study in *The Diabetes Update* newsletter.

Innovative diabetes service for youth and young adults

The Youth and Young Adult (YaYA) Diabetes Team at the Waikato Regional Diabetes



Service work with 15- to 25-year-olds with diabetes in the Waikato DHB catchment area. This equates to approximately 250 patients, with the majority having type 1 diabetes (75 percent). The team is made up of Dr Jo McClintock, clinical psychologist; Sonya Fraser, diabetes dietitian; Vikki Lowe-Reid, clinical nurse specialist; Vickie Corbett, nurse practitioner; and Dr Ryan Paul, endocrinologist.

The YaYA team restructured their clinic to provide a one-stop multidisciplinary shop after team discussions and suggestions from the ISPAD-APEG 2015 annual meeting on how to improve patient care. As a result, they now provide a 'wrap-around' service for diabetes care that allows patients to see all team members in one appointment. Approximately eight to ten young people with diabetes are seen in the YaYA clinic every Monday morning. The patients complete screening tools on arrival to identify recognised barriers to diabetes self-management, such as depression and eating disorders, diabetes-related distress and fear of hypoglycaemia.

Although patients will see all team members, the screening allows a more focused approach with targeted interventions to address specific challenges for every individual. For example, patients with significant diabetes-related distress will have extensive psychology input, whilst those with disordered eating will have significant dietitian and psychology input. In addition, all patients receive standard care, such as having their HbA1c and screening for microvascular complications performed, their annual biochemistry reviewed and their treatment regimen optimised.

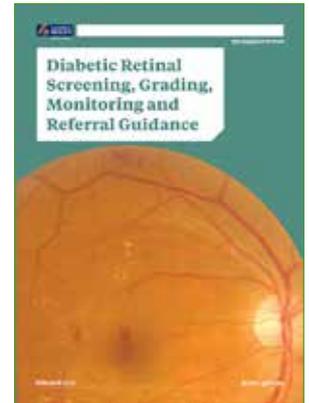
The team's screening tools have identified the importance of targeted multidisciplinary care for their patients. Over 25 percent of patients had a high level of general emotional distress, with an additional 5 percent meeting the clinical criteria for a depressive illness. With regard to diabetes-related distress, one-quarter reported concerns requiring further assessment for diabetes-related eating problems. Over one-third reported at least one issue indicating serious diabetes-specific emotional distress. Two-thirds reported at least one issue indicating moderate (but not severe) diabetes-specific emotional distress.

The team's new model of care has allowed a greater number of patients to see all members of the multidisciplinary team on a more regular basis to address their needs. They also provided greater access for their rural patients by performing 'travelling multidisciplinary clinics' to Thames Hospital. Feedback from patients on the new clinic model has been very positive, particularly as under the old model, patients often had serial appointments with different team members on different days. The YaYA team aim to formally review objective and subjective outcomes and feedback with the change in their clinic model in 2017, and this data will be presented nationally and internationally.

Diabetic retinopathy screening, grading and monitoring

New research commissioned as part of the Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance (launched in March 2016) provides evidence to support adoption of the community-based model (implemented in Capital & Coast, Hutt Valley and Wairarapa DHBs). The research indicates that the three-DHB model more efficiently uses existing health system resources, and more quickly identifies disease and improves outcomes, than the ophthalmology clinic-based model. Research findings will be published in the *NZMJ* in early 2017.

The Ministry team continues to disseminate the new retinal screening guidance and to support service improvements. See: health.govt.nz/publication/diabetic-retinal-screening-grading-monitoring-and-referral-guidance



Team weight-loss competition for at-risk Māori and Pacific peoples

A new team-based weight-loss competition for Māori and Pacific peoples living in Northland, Manawatū and Auckland is being trialled by Massey University's School of Public Health.

Seven teams of seven people who are at high risk of developing type 2 diabetes or cardiovascular disease are participating in the WEHI trial. The teams receive information on how to lose weight and earn points for achieving daily and weekly goals aimed at increasing physical activity and adopting healthier eating habits. A comparison group will complete blood tests and questionnaires and will be weighed at the beginning, after six months and at the end of the 12-month study. At the end of the first eight weeks, reductions in weight and waist circumference look promising for teams scoring highly on achieving the goals. An abstract to present on the WEHI trial has been submitted to the World Congress on Public Health, Melbourne, March 2017.

More information about the WEHI trial is available here: www.massey.ac.nz/massey/about-massey/news/article.cfm?mnarticle_uuid=9CB45D99-08D1-053D-0FDF-7264F1687F4E

WEHI was featured on TVNZ news recently: www.tvnz.co.nz/one-news/new-zealand/maori-and-pasifika-teams-embrace-competition-get-healthy-through-exercise-nutrition

Save the date – diabetes workshop 2017

The Ministry is pleased to announce that planning is under way for another diabetes workshop this year. The diabetes workshop provides an opportunity for DHBs, PHO and clinicians to discuss diabetes services and share innovations, updates and challenges to the sector. It will be held on 6 April in Wellington. The diabetes workshop will be held in conjunction with a long term conditions workshop currently being planned by the Ministry (5 April). We are very interested in your thoughts on what we can feature in the programme. Please email us (cvddiabetes@moh.govt.nz) with your ideas on topics for the day/s. An invitation and more detail on the programme will be circulated soon.

Update on SMS4BG (self-management support for blood glucose) project

In last April's *The Diabetes Update* newsletter (edition 6), we introduced the SMS4BG (self-management support for blood glucose) project. This is a free text message-based diabetes self-management programme developed by the National Institute for Health Innovation (NIHI) in conjunction with Waitemata DHB. It is a motivation and support programme designed to address the behaviours required for successful diabetes self-management and is made up of modules that can be tailored to each individual patient.

A randomised controlled trial of the effectiveness of SMS4BG funded by the Ministry and the Health Research Council, is now under way, in partnership with Waitemata and Auckland DHBs. A total of 366 patients with poorly controlled diabetes are enrolled in the study, and over 200 have completed their follow-ups.

Those receiving the text messages have provided very positive feedback about the programme:

'Thanks for the encouraging txts. They are constant reminders about the need to keep my diabetes under control and are very helpful.'

'I like the texts. They are like a little tap on the shoulder that stops you getting too complacent! Definitely make me think about it realistically.'

The study is due to be completed in August 2017, with results released later in the year. The research team are in the process of investigating avenues for ongoing delivery of the programme.

For more information, contact:

Rosie Dobson, SMS4BG Study Coordinator, National Institute for Health Innovation
School of Population Health, The University of Auckland
Phone: 021 767 437 Email: r.dobson@auckland.ac.nz



Knowledge, skills and career framework for diabetes dietitians

The Dietitians NZ Diabetes Special Interest Group (DSIG) were excited to launch the first New Zealand National Integrated Knowledge, Skills and Career Framework for Diabetes Dietitians in December 2016.

Registered dietitians deliver care and support to people with diabetes in a variety of settings, including hospitals, primary health care, public health settings and private practices. The National Integrated Knowledge, Skills and Career Framework for Diabetes Dietitians has been developed to deliver best practice in the nutritional management of diabetes and related conditions. It helps New Zealand

registered dietitians to demonstrate they are adequately prepared to provide the required care and education for the person with diabetes, whatever their practice setting and in accordance with their scope of practice.

It is essential that all dietitians have a basic level of competency in diabetes management, and there is a critical need for more dietitians with specialist/advanced skills in medical nutrition therapy for diabetes. This new framework enables dietitians to plan their careers in a structured way, providing guidance and support for them and their managers to plan ongoing professional development activities and meet post-registration training requirements. As a result, people with diabetes will benefit from a consistent and highly skilled dietetic workforce. In the future, we hope this facilitates better access to diabetes specialist dietitians across New Zealand.

For further information or a copy of the framework, please contact:

Shelley Mitchell MSc (Diabetes), NZRD, Diabetes Specialist Dietitian and DSIG Convener

Phone: (06) 350 8114 Email: Shelley.mitchell@midcentraldhb.govt.nz

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

On behalf of the Diabetes Team at the Ministry of Health: Gabrielle Roberts, Catherine Lofthouse, Dr Helen Rodenburg and Dr Paul Drury.

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

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