**Modified DCIP Collaborative Learning Session 1**

**25 July 2016**

**Notes from Otara Cluster**

Discussion on integration experiences and potential areas to focus on for improvement

* Shared learning as a practice is impractical as the whole practice cannot meet together
* Not able to align general practice and CM Health clinician availability for DCIP in some practices
* Suggest use of cluster MDTs for DCIP
* Only bring patients with multifactorial issues to MDT – straight forward issues such as medication should be directly addressed i.e. phone call
* Key learnings can be identified, documented and shared with all practice staff to inform practice improvements, patient reviews and audits
* Engagement between SMOs, DNSs, GPs and practice nurses useful to overcome clinical inertia
* Health coaches used to overcome patient inertia
* A patient focussed approach is fundamental – focus on what is important for patients
* Depression screening for all people with diabetes considered essential
* Dedicated practice nurse to facilitate a practice focus
* Health coach used for patient education, motivation, health literacy and checking understanding of advice provided
* Use of traffic light indicators to advise patients of recommended approaches has been well received
* Patients can be actively recalled for health coaching
* A 7 day intensive period for the patient has been used
  + Pharmacist
  + Community health worker
  + Care coordinator
  + Health coach
  + Practice nurse
  + General practitioner
* Hard to reach patients are an issue – follow up for large practices can consume a large amount of resource
  + If you can’t bring the patient in, do we take the service to the patient?
  + Would weekend clinics be effective for hard to reach?
* More dietician support needed
  + Language is important
  + Are “skinny palangi” dieticians acceptable to Pacific?
  + Nutritionists may be an alternative to dieticians
* A one stop shop clinic model preferred
* Goal setting must be achievable and realistic
* No need to refer patients to secondary for insulin initiation but insulin titration needs follow up
* Use DNSs to upskill practice nurses

**Actions**

* Identify and record key messages and learnings from MDTs to share with all participating practices and their staff
* SMO and DNSs need to be personally known to practice staff, contact details shared and discuss practice needs e.g. upskilling
* Availability of and roles of health coaches to be discussed between PHOs and practices
* Practices should identify a diabetes champion to lead practice quality improvement
* Greater access to dietician or nutrition advice to be addressed between DHB and PHOs
* Engaging hard to reach to be raised with locality leadership
* More comprehensive models of care provision (1-stop shops etc) to be discussed with allied health groups, localities and practices - DHB to lead