Chronic Disease: emerging research themes

Timothy Kenealy, Nicolette Sheridan, Harry Rea, Matthew Parsons
Integrated Care Research Group
South Auckland Clinical School, University of Auckland

RNZCGP Conference September 2011
3 very different studies

- **Consumers with chronic conditions**
  - TEC/STAR, J Parsons & N Sheridan, interviews >100 people chronic conditions in South Auckland, 2+ hospitalisations

- **Diabetes Tracking Study**
  - HRC, A Dowell PI, video of consultations with 35 people newly diagnosed diabetes, followed 6 months, in general practices and other venues in Auckland and Wellington

- **Magic in Manaia**
  - Unfunded, K Eggleton Masters, Care Plus programme, statistical modelling plus interviews
Consumers with chronic conditions - methods

• More than 100 interviews - Pacific, Maori or Asian + 2500 CATI
• 2 or more chronic conditions
• >50 years of age
• Mostly South Auckland
• All Pacific were island-born
• 2008 - interviewed in homes
  Samoan, Tongan, Cook Island Maori or English
• Transcribed, translated, analysis qualitative description
  Different sub-populations reported on
Consumers with chronic conditions - results

- Did not feel heard
- Want to discuss what matters most to them
- Unspoken resignation, frustration, even anger
- Non-concordance, often driven by social determinants, but not discussed / negotiated
- Value health professionals, but low expectations
- Still pursue relationship (often unrealised)
I have had [my GP] for a long time. But it is nice if they listen… not being talked down to… there has to be an element of trust… letting them into my life (Niuean woman, 54 years)

80 percent good… busy and does what he has to do. I would like to talk about some things a bit more… not always sickness… the diabetes [is] a bit more than just being sick (Asian man, 55 years)

I would like him [GP] to ask me how this is going and how that is going. I need to be told, but also listened to (Māori man, 68 years)

It is highly important to know spiritual health as we believe that we only live here temporarily, one day we will go (Tongan man, 57 years)
Diabetes Tracking Study - methods

• 35 patients – every interaction 6 months
  – Sampling purposive for age, ethnicity, gender
  – 14 NZE, 8 M, 6 P, 5 A, 2 Other
  – 22 < age 55, 13 ≥ 55

• 51 Health care professionals
  – 17 GPs, 22 Nurses, 1 diabetes specialist, 3 dieticians, 3 podiatrists, 2 optometrists, 1 health psychologist, 1 radiographer, 1 other

• 19 research sites

• Video, medical records, interviews, logs, field observations

• Practicalities
• Analysis by micro-level conversation analysis
• Analysis by more broad themes
• Not linked to outcomes
Diabetes Tracking Study - results

- Skilled, committed doctors, nurses and others
- Not always connecting or not remaining connected
- Often prioritising templates (nurses are directed to do tasks) with a focus on the disease not the person
- **Missed opportunities** – establish trust, understand...
- Moving too fast in (wrong) direction
- Constrained by time, but often inefficient
- Often same and different clinicians repeating same information regardless of patient interest at the time
Magic in Manaia - methods

- 1311 people with diabetes
  - 354 Maori, 957 non-Maori
- Maori with HbA1c mean 8.1% non-Maori 7.1%
  - >2 years HbA1c improved to that of non-Maori
  - LDL and systolic blood pressure ↓ for both
Magic in Manaia - results

![Graph showing HbA1c levels over months for Maori and non-Maori groups.](image)
Weaving these together

• If communication is central ...
• Tasks to achieve, lead to improved outcomes (Street et al, 2009)
  • Information exchange
  • Responding to emotions
  • Managing uncertainty
  • Fostering relationships
  • Making decisions
  • Enabling self management
Then to achieve communication ...

• Engagement – brings people to the consult and sets the stage
  • Inside the consultation
  • From outside the consultation

• Systematic care
  • Templates
  • Extended consultations
  • Nurse-led
Engagement within the consultation

- Compounding jeopardy (Sheridan et al, submitted)
  - Burden of disadvantage
  - Association with powerless
  - Onus is on the provider to create engagement
- You cannot guess or presume an individual’s wish for autonomy in decisions (Kenealy et al, 2011)
- Individuals vary hugely in their interpretation of the ‘same’ disease state (Sheridan et al, 2011)
Engagement within the consultation 2

• Easiest & most effective way to do this is to ask questions
  • Smart questions not Press Play
    – Smart answers (when you don’t know what the question is)
  • What is your most important concern?
  • Tell me what you already know about... (diabetes)
  • What worries you the most?
Systems to support engagement

• “Health Reality Show: Regular Celebrities, High Stakes, New Game. Integrated care in two general practices: a future model for managing complex patients in primary health care” (Sheridan et al, 2009)

Nurse home visit
Record review
Inter-professional case conference
Assertive follow up and intervention
Systems to support engagement 2

• Systematic care & protocols
  • anyone can provide the same standard of care as the expert who wrote the protocol (Houweling / Kenealy & Sheridan, 2011)
  • Reduces health inequities (Kenealy et al, 2010)
  • Overcomes clinical inertia (Phillips et al, 2001)

• Variability across DHBs by disease & ethnicity (Connolly et al, in press)
Thank you for your interest and participation

Kia ora koutou katoa