Clinical education from He Ako Hiringa

FOCUS

He Ako Hiringa
Learning Always

JUNE 2022

FEATURING
Curated content for primary care nurses, pharmacists and GPs

LEARNING TO MEET YOUR CPD NEEDS
Watch, listen, read, explore and reflect

EVALUATING PRESCRIBING TO INFORM CARE
The EPiC dashboard – bringing your data to life

Putting the spotlight on EQUITY

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Help yourself! It's free

Andrea Copeland, education lead
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If you've picked up this magazine, chances are that quality improvement is always on your radar, and you know that many New Zealanders don't have equitable access to funded medicines. You may feel that you've already done everything you can in your daily mahi to enhance quality and curtail inequities.

But could you do more? And if so, what can you change?

He Ako Hiringa provides a variety of evidence-informed educational tools and resources you can use to identify and reduce barriers that prevent people from accessing the medicines they need. Our content focuses on conditions significantly amenable to treatment with medicines – including gout, diabetes, cardiovascular disease and asthma – and on priority population groups. All our content is free and written specifically for a primary healthcare audience. *Focus* brings you a selection of our materials and showcases some of the 60 original resources we have produced since we began in 2020.

We know people learn in multiple ways, so we have put together a kete of useful material – for you to watch, listen, read, and reflect on. Webinars with subject experts where, at presentation end, you'll likely find answers to the questions you want asked. Dashboards where prescribers can access *their own* prescribing data for *their* patients and compare it with their practice's data and national data. Podcasts you can take with you on your weekly exercise kick. Videos to watch, some that dramatise real-life situations. Articles you can read at your leisure. Reflection activities and quizzes, that you can undertake when you're ready to, and earn CPD credits. Short, sharp, monthly bulletins and microlearning pieces that drill down to key issues in everyday practice. All are available to you through the He Ako Hiringa website at **akohiringa.co.nz**

We want to encourage clinicians to reflect on their current way of working and create change that makes positive differences to the people they care for.

Inside, you'll find six of our bulletins and a taste of the content you can expect to find at He Ako Hiringa, to help you to achieve practice excellence and support equitable access to funded medicines.

There's something for everybody, including you.

In this issue

JUNE 2022

Cover image:
Jo Hikaka

This resource is endorsed by RNZCGP, PSNZ and CNA(NZ) for up to **60 minutes** of professional development

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Sign up for our newsletter at **akohiringa.co.nz** and you'll get our latest resources as soon as they're released

iStock.com – Arthur Varlamov

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BULLETIN

Drivers of medicine access equity

Medicine access equity means everyone has a fair opportunity to obtain funded medicines to achieve their full health potential and no one is disadvantaged along the way. Some people may require more support than others for this to happen.

Māori receive medicines at lower rates than non-Māori, despite having higher health needs. This inequity, and the associated poorer health outcomes, is particularly obvious with asthma, cardiovascular disease, diabetes and gout. Other groups who experience medicine access inequity are Pacific peoples, former refugees, and those living in rural areas or with socioeconomic deprivation.

Medicine access is a broad concept that is not solely about being able to obtain a medicine. It includes aligning appropriate prescribing and medicines optimisation with a person's risk factors and stage of disease, in order to improve health outcomes.

Published April 2021
akohiringa.co.nz

Five primary drivers facilitate medicine access equity in Aotearoa New Zealand

Medicine availability – Prescriber awareness and knowledge of the availability of funded medicines play a role in ensuring equitable access.
Medicine accessibility – Physical and timely accessibility to medicine relates to how well services are designed to meet patients' access needs, for example, opening hours, follow-up appointments.
Medicine affordability – Prescriber, prescription and indirect costs (eg, transport, parking, time off work and childcare) can significantly limit the affordability of medicines.
Medicine acceptability – Empowering patients by involving them in decision-making, asking about their beliefs, considering their health literacy and providing information in an appropriate language, builds trust and contributes to medicine acceptability, improved adherence and better health outcomes.
Medicine appropriateness – High quality, effective prescribing that meets the patient's needs and avoids unwarranted variation is required. This may be achieved by combining clinical expertise and evidence-based practice with patient preference, priorities, values, experiences, culture and beliefs.

Think about the five drivers of medicine access equity and where you can make a difference.

The referenced online version is available at **akohiringa.co.nz**

Equitable access to medicines improves health outcomes

aHAH! MOMENT

Medicine affordability

Up to 40 per cent of people continue to pay prescription copayments even though they are entitled to an exemption.

No person or family should pay more than $100 per annum for subsidised medicines.

Are your patients making the most of the prescription subsidy card scheme through their pharmacy? Find out more at tinyurl.com/subsidy-scheme

To see all our bulletins go to akohiringa.co.nz and click 'HAH Bulletins' under the RESOURCES tab

ARTICLE

EPiC improves prescriber reporting, a first for New Zealand

Alesha Smith

EPiC, a new prescribing reporting tool published by Pharmac-sponsored educators He Ako Hiringa, sets a new standard for health data reporting and is now online.

Using data sourced from the Ministry of Health national collections, with extensive contribution from primary care clinicians and Pharmac, a series of data themes and stories have been developed, that quickly allow clinicians to evaluate their prescribing against national problems of prescribing practice.

Asking the right questions – reflective education templates and more. Wrap-around, accredited, educational activities that can be used by doctors, nurses or pharmacists, sit alongside the EPiC data themes.

The resource, developed by data insights company Matui, and web development company Communica, allows any user to access and interpret data to help inform personal or team quality improvement or educational initiatives. Presenting huge sets of data visually in a series of interactive charts allows users to compare medicine use across different populations and demographics by prescriber, enrolled practice population and nationally.

EPiC lead analyst, Dr Alesha Smith, says "we are delighted that we have been able to achieve simple visual representation of the valuable, but complex, national collection data in EPiC. It's easy now for any user to search for variances in their area of practice, specialism or interest".

One of the EPiC themes, the Annual Report, combines over 10 million rows of data to enable usage comparison of 100 medicines across different ages, genders, ethnicities, and deprivation quintiles. The report helps primary care clinicians quickly focus on key problems of national prescribing practice such as polypharmacy, inappropriate prescribing, and medicine underutilisation in different populations.

"In the past, as medicine data sets are so large, we were often forced to restrict our analysis to smaller subsets to gain meaningful insights," explains Dr Smith.

"The software and approach we have taken with EPiC has allowed us to show

users big data in quite a different way, starting with a snapshot of the national data set, then dropping it down to practice, and then practitioner views."

Users often ask how EPiC differs from the Health Quality and Safety Commission's Atlas of Health Care Variation dashboards. Dr Smith explains "The Atlas and EPiC use the same data sources; however, EPiC is more current (displaying data to January 2022 at present), is updated quarterly and is solely focused on medicines. Additionally, EPiC can show prescriber and practice data but the Atlas cannot."

PHO or DHB data dashboards are also slightly different from EPiC because they typically only include information for the PHO area or DHB region. They may not assist the user with a clear definition of the prescribing problem for which the data story has been developed. PHO or DHB dashboards are also capable of displaying patient-level data, which is not available in EPiC.

Five EPiC data themes are currently available including gout, diabetes, CVD, cilazapril and the Annual Report. Asthma is due for release later this year. Sixteen different data stories are explored within the five themes.

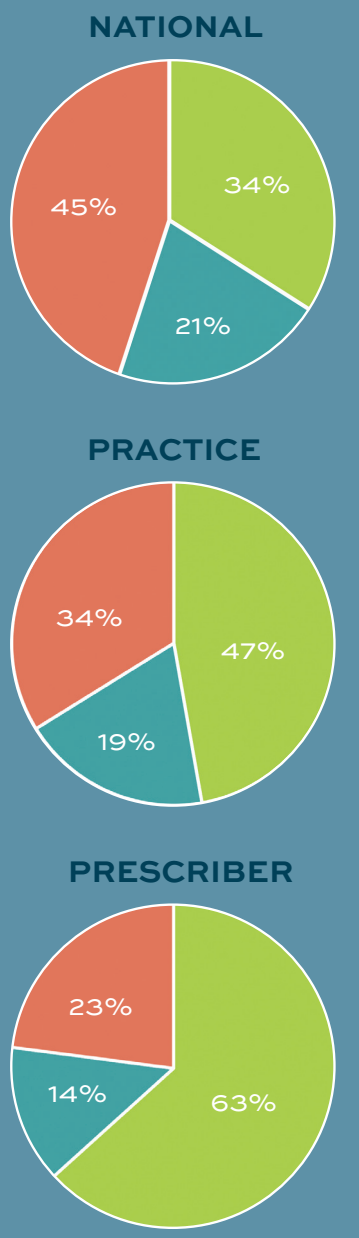
Prescribers can sign up to EPiC at epic.akohiringa.co.nz

To view national data go to akohiringa.co.nz and click 'Go to EPiC' under the EPIC DASHBOARD tab

For a prescriber demonstration dashboard go to akohiringa.co.nz and click 'EPiC Demo' under the EPIC DASHBOARD tab

Educator, analyst, or quality advisor? He Ako Hiringa staff can help you use EPiC with a group of practices. Call Programme Manager **Anna Mickell** to discuss on **021 488 709** or email **anna@akohiringa.co.nz**

Māori patients with gout who over the last 12 months have had regular, any, or no dispensing of ULT*



*ULT = urate-lowering therapy
Regular = 3 or more ULT prescriptions
Any = one or two ULT prescriptions

Breaking barriers to equitable care

He Ako Hiringa has many resources to help you and your team build on your equity knowledge. Check out a sample below, and head to our website, where you'll come away with practical ideas to support your patients to obtain equitable access to medicines.

A STORY OF CHANGING LIVES: PRESCRIBING EQUITY THROUGH BETTER USE OF MEDICINES

5 mins

The call for equity in healthcare is not new, but it is louder than it has ever been before. The release of the Waitangi Tribunal report on primary healthcare claims, the investigation of the Health and Disability System Review Panel and a growing swathe of published research underlining inequitable health outcomes for Māori and Pacific peoples and disadvantaged populations, add to the zeitgeist. To broaden understanding of the importance of access to medicines to improving equity in health outcomes, the He Ako Hiringa team spoke to a number of primary care clinicians and stakeholders around the country.

IMPROVING MEDICINE ACCESS EQUITY IN PRIMARY CARE

42 mins

How can you make a difference to medicines access equity "on the ground"? Pharmac access equity manager Sandy Bhawan talks through the research and approaches developed by Pharmac to help achieve medicine access equity, and what you can do. Along with developing a medicines access equity monitoring outcomes framework, Pharmac has the intent of learning what is happening "from the ground", which has resulted in three on-the-ground projects looking to improve medicine access equity. Rural GP Dr Emily Gill co-led one of these projects in the Eastern Bay of Plenty, and talks about equity issues and her work improving medicines access equity at the remote practice Te Whānau ā Apanui Community Health Centre.

Kevin Pewhairangi

23 mins

MEDICINE ACCESS EQUITY: A CALL TO ACTION

Do you need help improving your understanding of medicine access equity issues? In this video you will hear from a number of primary healthcare professionals who are working to improve equity outcomes in the services they provide to patients. Pharmac has identified five drivers of medicines access equity that can have a real impact on patient outcomes: availability, accessibility, affordability, acceptability and appropriateness. Gisborne pharmacist Kevin Pewhairangi (Ngāti Porou) and others explain what these drivers actually look like at the coalface of primary care.

For more resources relating to medicine access equity go to akohiringa.co.nz and click 'Equity' under the TOPICS tab

Being culturally competent is not enough

Focusing on practical cultural competencies, such as how to engage, does little to encourage practitioners to confront health inequities, and is not enough to improve health outcomes. A shift from cultural knowledge to an approach based on cultural safety will support the achievement of equitable access to healthcare and medicines for people of all cultures. Cultural safety necessitates practitioners critically question themselves and the possible impact that their own culture, history and attitudes may have on the patient.

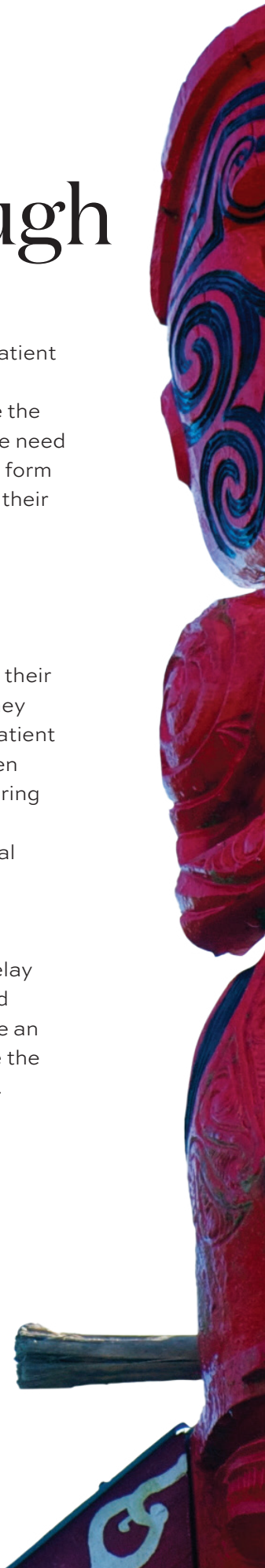
What's required to practise cultural safety?

Below are some points to assist in embedding cultural safety into your practice.

- Acknowledge your biases and understand how they impact on your interactions.
- Work on underlying prejudices and stereotypes (eg, do you believe your patient is not attending for their medicines because different groups are not as able or motivated to be as healthy as other groups?).
- Recognise the inherent power imbalance in the practitioner–patient interaction.
- Engage with your patient, share the decision-making – balancing the need for best clinical pathways – and form a treatment plan that fits within their cultural context.
- Don't impose your own cultural beliefs, values and practices on patients, and do respect theirs.
- Understand that your patient's beliefs and values will influence their perception of illness and how they manage their health (eg, your patient may have had to choose between picking up their medicines or caring for a relative).
- Recognise that a patient's verbal and non-verbal communication styles may not be the same as yours, and that you will need to adapt (eg, ask your patient to relay their understanding of when and how to use their medicines). Use an interpreter if necessary. Include the patient's whānau if appropriate.
- Learn to recognise when your actions may not be acceptable to your patient.

The referenced online version is available at **akohiringa.co.nz**

Published June 2021
akohiringa.co.nz



The pou atop a waharoa (gateway) can symbolise a new beginning or journey eg, to start learning tikanga Māori

iStock.com – LazingBee

aHAH! MOMENT

Cultural competence vs safety – related, but different

A culturally competent practitioner knows about the beliefs and behaviours of patients from different cultures, and has the skill to apply this knowledge to healthcare delivery. Although important, cultural competence alone is not enough to improve equitable access to healthcare.

Practising cultural safety requires practitioners to critique tacit power structures, by exercising self-reflection and awareness, and addressing their biases, attitudes and assumptions that may affect provision of healthcare. Culturally safe practice engages patients, empowering them to be involved in decision-making and contribute to achieving positive, equitable health outcomes.

Meeting the needs of Māori

The equity resources on our website are some of our most read, most watched and most listened to content. They are designed to help all primary care clinicians to build on their existing knowledge and soak up some new ideas to put into action with their practise.

The resources below feature stories from a number of primary healthcare professionals who are working to improve equity outcomes in the services they provide to patients.

20 mins

MEETING THE NEEDS OF MĀORI

Māori attitudes to healthcare today are deeply rooted in New Zealand history. “When a Māori cabinet minister is diagnosed with stage III cervical cancer because she didn’t feel confident talking to her GP about persistent symptoms for up to six months, then everyone needs to sit up and take notice.” Kaitaia pharmacist Deborah Bassett-Clarke makes this point in her article discussing reasons why the current model of pharmacy practice does not always meet the needs of Māori and may actually cause health inequities. Understanding these factors is an important first step to improving outcomes for Māori.

6 mins

UPDATED DIABETES HEALTHPATHWAYS BRAVELY PAVED WITH EQUITY

Te Manawa Taki Region Community HealthPathways has gone live with two updated diabetes pathways. Careful writing and editing, and an equity lens, have been instrumental in the updates, helping to reduce unnecessary variation in treatment plans and outcomes. The new pathways incorporate international best practice, the latest funded medication options from Pharmac, and links to secondary health providers in each part of the region. They also highlight inequities and provide a standardised framework to try and eliminate variation in care caused by location or ethnicity. Take a look and get on board!

Jo Hikaka

20 min

MEDICINES AND OLDER MĀORI

Want to hear directly from kaumātua about their experiences of medicines? Like some take-home messages on how to better reach your patients? Join pharmacist Dr Jo Hikaka (Ngāruahine) as she takes a tour through her PhD research project on medicine use in older Māori.

Dr Hikaka's four short videos provide a starting point to understand where ethnic disparities exist and where and how you may be able to make a difference in this area. She introduces concepts around why extra care is needed with medicines use in older adults, how to measure the quality use of medicines, and what New Zealand data show us about inequities in medicines use in older adults. Healthcare providers can hear from kaumātua about their experiences with medicines and medicines-related services, enabling awareness about the real-life impacts of inadequate prescribing on older Māori. The final video also presents posters developed from the experiences of older Māori. These are available in te reo Māori and English and can be downloaded.

reflect

After watching the videos and exploring the additional resources in this course, you can complete an independent reflection which will help you evaluate and improve your management of older Māori. Simply download the template we've provided and use our examples to help you complete the activity.

Pharmacist Noni Richards is passionate about using data to improve health outcomes. Dr Richards is one of the team who developed the EPiC gout dashboard - explore your data at epic.akohiringa.co.nz

BULLETIN

Beyond unreasonable gout!

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The jury is in – usual gout care isn't working well, especially for Māori and Pacific peoples, who are disproportionately affected by this common disorder. What potential tools are readily available to reduce gout harm? Specific clinician actions!

Scout, enquire

If a Māori or Pacific person aged between 20 and 40 presents with joint pain, consider gout as a potential cause. Māori and Pacific peoples are, respectively, two and three times more likely to get gout and at a younger age than non-Māori, non-Pacific peoples.

Are you contemplating prescribing an NSAID? While effective for gout, repeated exposure is not without risk, and use is high, especially for Māori and Pacific peoples. Before writing or dispensing another NSAID prescription for gout, ask yourself – would this person benefit from long-term urate-lowering therapy (ULT) now?

Shape, identify, act

Peoples' capacity to engage, accept and self-manage their gout varies significantly.

Patients may blame themselves for their gout and feel whakamā (shame), holding on to outdated yet strong beliefs their gout is caused by overindulgence in food and drink. Raise awareness of genetic predisposition to gout in Māori and Pacific peoples; this can reduce whakamā and encourage treatment programme participation. Talk about food and drink as triggers only.

Daily, life-long treatment can be challenging and hard to accept. Support patients in engagement, and share decision-making.

Be aware Māori and Pacific peoples are less likely to receive regular ULT than others. Pharmacists, especially, have an opportunity to detect irregular ULT dispensing. Be alert to the person with joint pain or repeated purchases of NSAIDs – reach out to prescribers.

Reflect

Dynamically building patient knowledge and skills through health literacy can overcome barriers to care. Hone your communication skills and provide consistent messages and individualised support. Encourage treatment persistence through trustworthy and relatable information delivery.

The referenced version is available at **akohiringa.co.nz**

Consider gout in young Māori and Pacific peoples who present with joint pain

aHAH! MOMENT

Team Gout

Usual gout care is variable, and different management approaches are needed, particularly for Māori and Pacific peoples.

To reduce gout harm, healthcare providers can:

Scout. Aged 20 to 40, joint pain? Think gout.

Enquire. Question and/or review recurrent NSAID-only treatment for gout.

Shape. Explore beliefs about causes and treatments. Talk genetics.

Identify, act. Prescribers – preventive medicine early and regularly is essential. Pharmacists – look for patterns of irregular dispensing.

Reflect. How is your communication helping people see a better future?

Go to tinyurl.com/HQSC-HeathLit for health literacy resources.

Go to arthritis.org.nz/gout-arthritis for gout educator support.

Published October 2021
akohiringa.co.nz

Team gout: A joint effort

If you're looking for gout resources, a good starting place is our online gout resource hub, where you'll find up-to-date information. We've linked resources from multiple providers – articles, webinars, podcasts, videos, clinical audits, webpages, online courses, patient resources and contacts – all in one central repository! See below for examples of content then check out the gout resource hub at akohiringa.co.nz

21 mins

BEYOND MEDICINES FOR GOUT

Gout is not a benign medical condition. It causes debilitating pain and is often associated with other diseases, and with drug-related morbidity and mortality. Furthermore, it impacts on the social, psychological and spiritual wellbeing of the affected person and their whānau. In New Zealand, the burden of gout falls particularly on Māori and Pacific peoples and inequities persist because of poorly managed gout.

In this informative article, prescribing pharmacist Dr Linda Bryant (ONZM) tackles long-held beliefs about the causes of gout. Dr Bryant discusses triggers, treatment of acute flares, long-term management, and delves into the pharmacology of gout medicines and potential drug interactions.

90 mins

ACHIEVING EQUITY IN GOUT MANAGEMENT

Rheumatologist Professor Lisa Stamp emphasises the high rate of gout in New Zealand and the disparities in both disease burden and treatment, in this information-packed webinar. Professor Stamp describes drug treatments, including the potential for overuse of NSAIDs and resultant harm, and finishes with novel interventions undertaken by healthcare practitioners trying to improve gout management. After listening to this 45-minute presentation, you will come away with strategies for how you can improve the management of gout for your patients.

Pharmacist and data consultant Dr Noni Richards follows up with an introduction to the EPiC gout dashboard, outlining how it can be used to highlight and address inequities. Listeners then pick our gout experts' brains in a 30-minute all-about-gout Q&A session. So much learning value in a mere 90 minutes!

To access all our gout content go to akohiringa.co.nz and click 'Gout' under the TOPICS tab

Linda Bryant

30 mins

PODCAST EPISODE THREE: LET'S TALK GOUT (PART 1)

The well-known proverb "it takes a village to raise a child" originated in Africa, but here in New Zealand "it takes an entire team to treat gout". How can we better communicate with people with gout, to improve health outcomes? We talk to three experts in the gout and health literacy field and explore patient attitudes towards gout and how the use of the Ask, Build, Check health literacy framework can help healthcare providers to better communicate with patients. Our first guest is academic rheumatologist Professor Nicola Dalbeth, whose work focuses on understanding the impact of gout and mechanisms of disease. Next up is Carla White, director of Health Literacy New Zealand; Ms White helped develop the ABC framework. Finally, we hear from health psychologist Meihana Douglas whose postgraduate research focused on perceptions of gout by rural Māori, and general attitudes towards gout as an illness label.

To experience the ABC framework in action, listen to **Let's talk gout (part 2)**, which follows on from part 1, and features a scripted conversation between a prescriber and her patient with gout.

Starting a medicine? Accentuate the positive

A new medicine is available that may benefit your patient, and together you must consider its appropriateness – your patient needs to be well informed. How you discuss the medicine is pivotally important. It is central to whether your patient takes the medicine and how long they remain on it, and may influence treatment benefit and the severity of any adverse events. Reduced efficacy, symptom worsening and new side effects are all possible, too, simply as a result of your discussion!

"A one-size-fits-all approach clearly doesn't work; we need to be more flexible and think more deeply around non-adherence and how we can improve it" – Dr Rinki Murphy, Inequities in diabetes webinar, 18 November 2020

Conversations between patient and prescriber should include an emphasis on the positive attributes of a medicine and reasons for its initiation rather than focusing only on the likelihood of adverse events – which need to be placed in context of treatment benefit. Accentuating the benefits optimises the powerful placebo effect, a major part of treatment success, and minimises the nocebo effect (adverse effects induced independently of active treatment).

Prescribers are instrumental in framing a medicine positively or negatively, setting patient expectations. Optimising these expectations during a short consult can enhance and sustain benefits. Conversely, highlighting negative information may lead to increased experience, and reporting, of adverse events, and to poor adherence.

Prescribers influential

Prescriber's own beliefs significantly influence how a patient feels about a medicine. A prescriber who is hesitant, diffident or uncertain about a medicine can transfer these feelings during the consult, affecting how the patient experiences and accepts the medicine. Your patient may have already conducted research via the internet or social groups and hold pre-conceived beliefs about medicines. Encourage positive conversations by creating environments where patients feel comfortable introducing their concerns and beliefs.

"Repetition is a great way to consolidate new information that patients might be hearing for the first time; if people don't remember information once they leave the clinic, or a week later, then how useful is that consult going to be?" – Meihana Douglas, Legendary Conversations podcast, episode three, November 2021

Using the Ask, Build, Check health literacy framework may help to identify specific patient concerns prohibitive to taking a medicine – target your conversation to these.

The referenced version is available at **akohiringa.co.nz**

Published December 2021
akohiringa.co.nz

Prescribers are instrumental in framing a medicine positively or negatively

aHAH! MOMENT

Nocebo effect

Expectations and perceptions of harm from a medicine can cause a patient to actually experience adverse events: the so-called nocebo effect. Reasons patients may experience this phenomenon include, among others, perceived sensitivity to medicines' effects, personal beliefs about medicines, and interactions with healthcare professionals.

Therefore, how medicines information is communicated is crucial: focus on treatment goals and expected benefits; balance adverse event risk with treatment benefit; use positive framing (eg, 90 per cent of patients will not experience headache); state facts about adverse events; and avoid use of emotive language.

Legendary conversations

The Legendary Conversations podcast series covers a range of key topics, aimed at helping clinicians to have the most effective conversations with their patients.

17 mins

EPISODE ONE: INITIATING NEW MEDICINES (PART 1)

In this first episode of the He Ako Hiringa *Legendary Conversations* podcast series, we talk with health psychology professor Keith Petrie about the psychological effects of taking medicines, and what primary healthcare professionals need to know. Professor Petrie discusses why prescribers exhibit new medicines hesitancy, how this might impact the patient, and how to minimise the nocebo effect.

11 mins

EPISODE TWO: INITIATING NEW MEDICINES (PART 2)

In episode two of *Legendary Conversations* you'll hear a scripted conversation that uses the three-step Ask, Build, Check health literacy framework when talking with a patient about starting a new medicine. The podcast is halted at various timepoints for learning moments that highlight the three steps of the framework, as well as other important lessons of note.

You can access all our podcasts at akohiringa.co.nz – go to the RESOURCES tab and click on 'podcasts'

Keith Petrie

reflect

REFLECTION ACTIVITIES: LEARNINGS FROM LEGENDARY CONVERSATIONS

Use the learning from this podcast, and others in the series, for your continuing professional development. Simply download the template we've provided and use our examples to help you complete the activity.

DID YOU KNOW?

You can find all our reflection activities at akohiringa.co.nz – go to the RESOURCES tab and click on 'reflection activities'

Considering the new T2D agents

In 2021, two new second-line type 2 diabetes medicines became funded for patients with diabetic kidney disease, known cardiovascular disease or five-year CVD risk ≥15 per cent. Funding criteria also cover Māori and Pacific peoples and early onset T2D.

But is empagliflozin or dulaglutide better suited to your patient? Both agents reduce CVD mortality and slow progression of renal disease, independent of effects on glycaemic control, although dulaglutide is yet to be shown to prevent dialysis or renal death. Empagliflozin, in particular, reduces hospitalisations with heart failure. If HF or diabetic kidney disease is predominant, empagliflozin is preferable; if cerebrovascular disease predominates, dulaglutide is likely favoured. Unlike empagliflozin, some data suggest dulaglutide may be effective in primary prevention of CVD. Neither medicine has yet been shown to prevent diabetic kidney disease.

Both agents improve glycaemic control and blood pressure. Dulaglutide likely has a greater effect on reducing HbA1c and weight than empagliflozin, but less effect on BP.

Published August 2021
akohiringa.co.nz

Other influences matter

Always consider whether potential adverse effects outweigh benefits, particularly in frail patients or those with short life expectancy.

People with personal or family history of medullary thyroid cancer cannot be prescribed dulaglutide, nor is it recommended in people with severe gastrointestinal disease or previous pancreatitis.

Empagliflozin must be used with caution in people at high risk of diabetic ketoacidosis; for those with previous history of DKA, specialist approval is recommended. Caution is needed if there is a high risk of volume depletion as empagliflozin promotes glycosuria and associated osmotic diuresis.

If your patient has previous severe or recurrent genitourinary infections, or is likely to be on a low carbohydrate diet and/or have significant alcohol intake, empagliflozin is not for them.

Neither agent should be used in pregnancy, breastfeeding or in children aged <18 without specialist approval. Finally, dulaglutide can be used safely in patients with estimated glomerular filtration rates (eGFR) between 15 and 30mL/min, but empagliflozin cannot.

Rinki Murphy

Pro-equity access criteria exist for both empagliflozin and dulaglutide. You can hear more about equity-focused healthcare in the recorded webinar 'Inequities in diabetes', presented by Dr Rinki Murphy on 18 November 2020

aHAH! MOMENT

Empagliflozin or dulaglutide?

When initiating either empagliflozin or dulaglutide, the newly funded second-line type 2 diabetes agents, choice is based primarily on predominant comorbidities, clinical features and tolerability.

But patient preference is an additional factor, with administration route influential. Dulaglutide, a subcutaneous injection, is self-administered weekly. Empagliflozin is a daily oral tablet; combination empagliflozin/metformin is available, which may aid adherence.

Switching from empagliflozin to dulaglutide is straightforward, but vildagliptin, if used, must be stopped. Remember, empagliflozin and dulaglutide can be used together, but one will need self-funding.

The referenced version is available at **akohiringa.co.nz**

You can access all our diabetes-related content at akohiringa.co.nz – go to the TOPICS tab and click on 'Type 2 diabetes'

Providing answers about new agents for type 2 diabetes

If you have questions about dulaglutide and empagliflozin, you may well find the answers on our website. While you're there, you can pick up some tips on how to support patients to take the new diabetes medicines. Below is a taster, with full content available at akohiringa.co.nz

30 mins

INITIATING TREATMENT WITH DULAGLUTIDE OR EMPAGLIFLOZIN: ALGORITHMS, NOTES & TALKING POINTS

At last! New diabetes medicines dulaglutide and empagliflozin can be prescribed for adult patients with type 2 diabetes, and funding is available if access criteria are met. You've made the decision to consider treatment with dulaglutide or empagliflozin, so where do you start? He Ako Hiringa's resources guide prescribers through this process using a stepwise approach to considering the suitability of these medicines for your patients. Two separate resources, containing algorithms with accompanying prescribing notes and points to discuss with your patients, are available for download.

45 mins

DULAGLUTIDE AND EMPAGLIFLOZIN: YOUR QUESTIONS ANSWERED – PART 1

Hands up, it's question time. Webinars held in early 2021 produced a volley of clinical questions about the newly funded diabetes medicines dulaglutide and empagliflozin.

Reviewed by Waikato diabetologist Dr Ryan Paul (Ngāti Maru), and current as at 23 April 2021, content has been grouped by the following section headings:

- talking with your patient
- genitourinary/renal
- general
- cardiovascular
- ketoacidosis
- funding and Special Authority.

Check it out, it may save you a bucket of time.

Ryan Paul

45 mins

DULAGLUTIDE AND EMPAGLIFLOZIN: YOUR QUESTIONS ANSWERED – PART 2

Q: Why is high alcohol consumption a factor favouring the use of dulaglutide over empagliflozin?
A: Because chronic high alcohol intake is a risk factor for diabetic ketoacidosis.

The Q & A part 1 was so popular that He Ako Hiringa produced a second list of your questions on dulaglutide and empagliflozin answered – part 2. This new resource covers discussions from webinars held in August 2021.

Again, the content has been reviewed by Dr Paul, and is current at the time of its publication on 14 October 2021.
Section headings for part 2 include:

- talking with your patient
- dulaglutide or empagliflozin
- dosing and administration
- use in particular patient groups
- reduced food intake, elective surgery, sick-day management
- funding and Special Authority.

See how many people are on the new T2D medicines at akohiringa.co.nz – go to the EPIC DASHBOARD tab and start exploring

aHAH! MOMENT

Compliance, adherence, concordance – confused?

Medicine compliance is an authoritarian term implying prescribers must be obeyed and patients are at fault if medicines are not taken as instructed.

Adherence is the extent to which a patient's behaviour matches agreed recommendations from prescribers – it assumes an equal relationship between the two parties.

Concordance implies a decision-making partnership based on trust between a well-informed patient and an understanding prescriber.

Whatever terminology is used, studies show that differences in health literacy, medicines access, attitudes to health and prescriber perceptions, may contribute to sub-optimal use of medicines and poor health outcomes.

The referenced version is available at **akohiringa.co.nz**

ARTICLE

Failing as a pro-equity practitioner

Contributor: Lucy O'Hagan
First published in *New Zealand Doctor Rata Aotearoa*, 27 April 2022

I'm trying to be a pro-equity practitioner, but it turns out I'm not doing so well.

It's just really, really hard to create more equitable health outcomes. I mean well; I've always hated injustice.

In my room, I'm armed with HealthPathways and motivational interviewing skills, but it's a big ask to get someone who feels perfectly well to take four pills for diabetes, so they will still feel well in 10 years.

I'm asking them to be a believer, and to believe so strongly that they will swallow those pills every morning and every night, even if the pills make them feel worse.

I'm a doctor, so I am a believer: "Take those medications and you will be saved." So, for me, there is great distress when patients don't convert, and I can see the bad medical outcomes ahead.

Today I'm worrying about a young woman with type 2 diabetes. She has had a glycated haemoglobin over 100, for five years. She is 26 years old.

I did well when I saw her eight months ago. She even had a first shot of dulaglutide and was excited about how easy this was going to be. Could she tell her sister about this new wonder drug that you only inject once a week?

But we have never seen her again, she never picked up the prescription, she doesn't answer our calls. I have sent texts full of encouragement and lightness and yes, doses of aroha, but still she has not come in the door.

I'm wondering if the door is the problem.

When I go through that door, I'm entering my place in the world. I've probably just parked my late-model hybrid Yaris and am carrying my packed lunch of home-made

iStock.com – skegbydave

goddess bowl (because I'm concerned about my cholesterol, even though I'm guessing my life expectancy will be decades longer than that of the patients I see, and the ones I am not seeing).

I know that any cross-cultural communication is going to be tricky, and I even understand that medicine in itself is a cultural construct. Our health outcomes and health literacy are actually medical outcomes and medical literacy as defined by our world view. Another view of health may be very different, perhaps incomprehensible to me.

I'm trying to understand why she can't come through the door into my room, because I'm pretty friendly, but I know that isn't enough.

I'm wondering if maybe the door means time and cost, and opens up the shame of the scales, maybe an unpaid bill and the blood test not being good enough. And the doctor looking disappointed while trying to be nice, because the doctor knows a pro-equity practitioner is measured on how well they get the blood sugars and blood pressures down, and the life expectancy up. In truth, I'm scared because the stakes are high: people will die young.

So I worry about her and the women in their 30s with blood pressure 180 systolic not just once, but also two and three years ago, and the man in his 30s already on dialysis who probably won't get a transplant because his second name is DNA. This is such a common second name here that I'm wondering if it means Door Needs Attention (rather than Did Not Attend).

"I'm trying to understand why she can't come through the door... I'm pretty friendly"

And I am wondering if someone from her world needs to help her through.

That door between the world of her life and my room full of medicines is really a threshold, a liminal space. I remember someone telling me about the concept of the va, the meeting of two worlds, the sacred relational space.[1]

"Pay attention to the va," says my wise friend Ben Gray. "Without relationship, you can do nothing."

Lucy O'Hagan is a medical educator and specialist GP working in the Wellington region

Reference

Tiatia J. Commentary on 'cultural diversity across the Pacific': Samoan cultural constructs of emotion, New Zealand-born Samoan youth suicidal behaviours, and culturally competent human services. *J Pac Rim Psychol* 2012;6(2):75–79. https://bit.ly/38sTmzC

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