Western Sydney Diabetes

Beating Diabetes Together

TAKING THE HEAT OUT OF OUR DIABETES HOTSPOT

phn WESTERN SYDNEY An Australian Government Initiative

NSW GOVERNMENT Health Western Sydney Local Health District

EVOLVE
EDUCATE
ENGAGE

The Royal Australasian College of Physicians

RACP Congress 2016 / Adelaide Convention Centre 16-18 May 2016

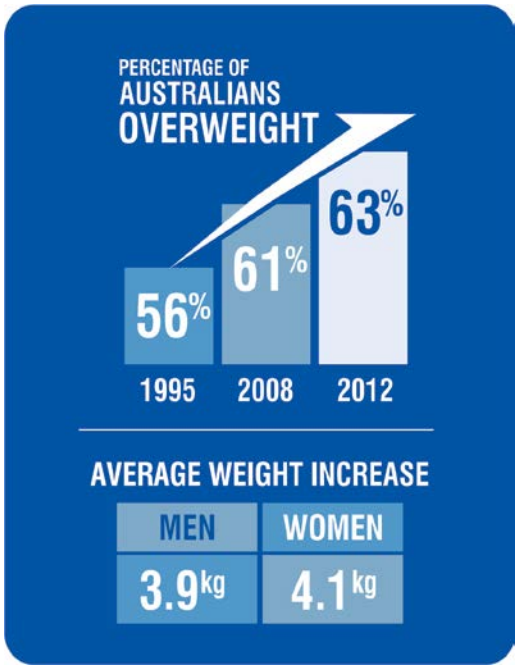
PROF GLEN MABERLY

Program Lead, Western Sydney Diabetes
Staff Specialist Endocrinology
Blacktown and Mt Druitt Hospitals

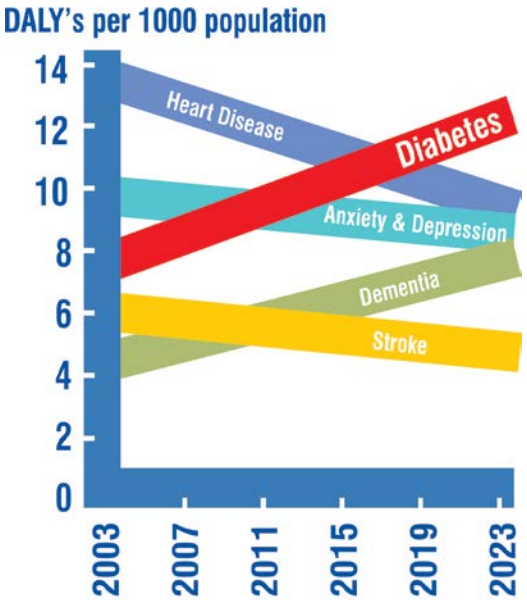
CONTENTS

Western Sydney Diabetes

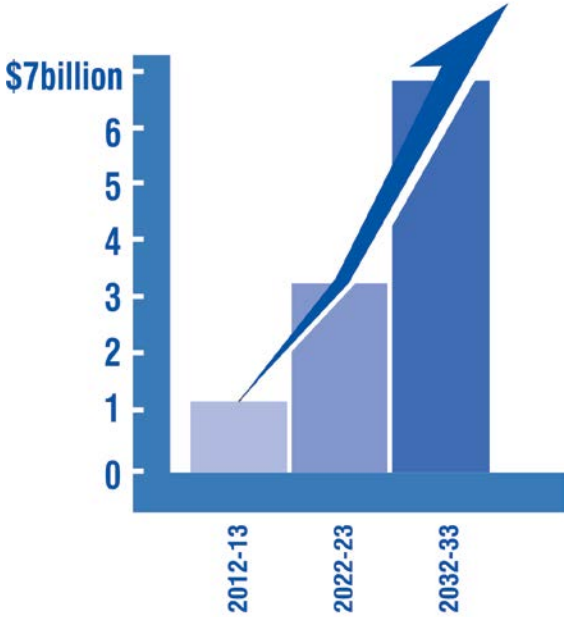
THE DIABETES EPIDEMIC



Overweight problem



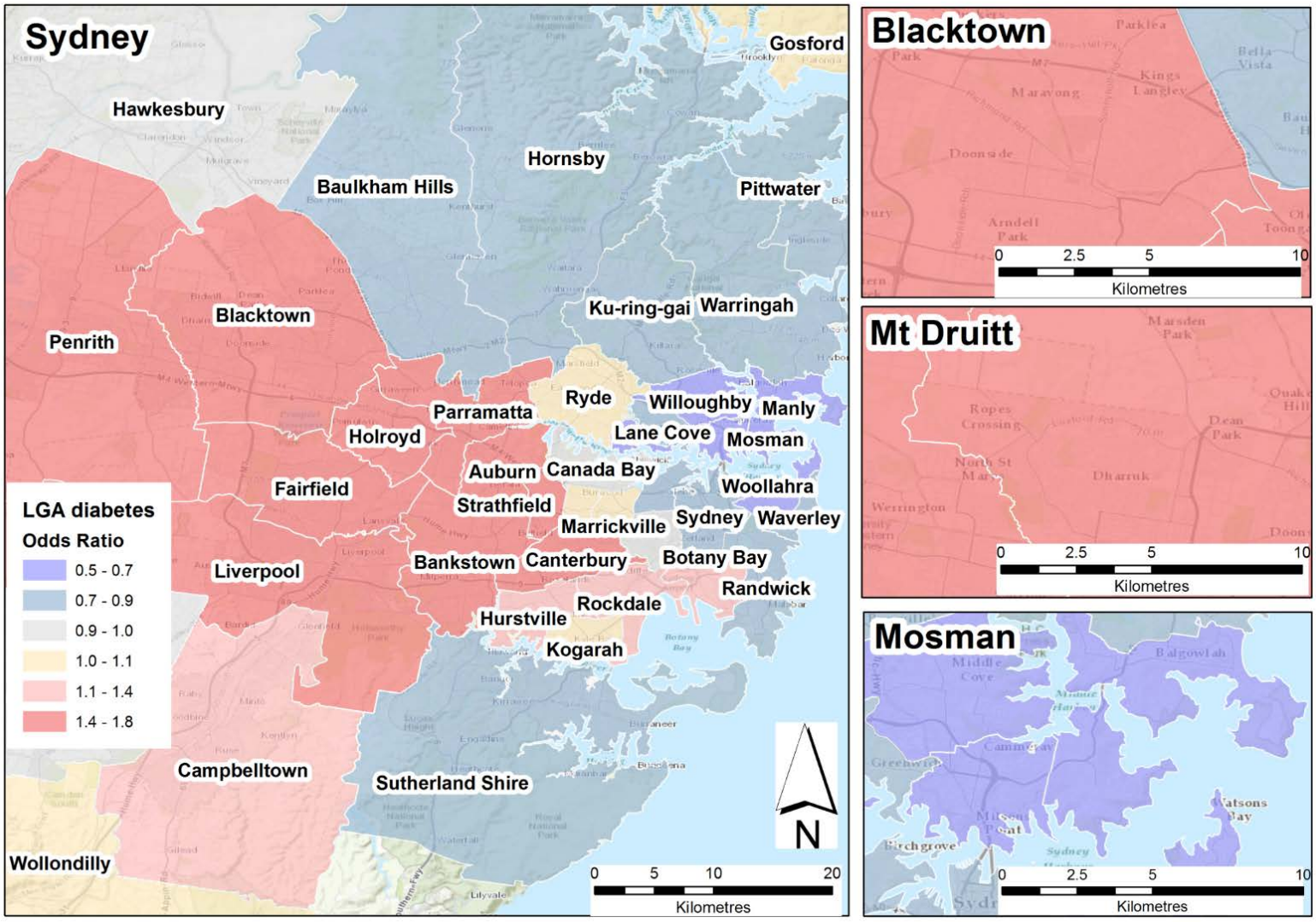
Diabetes trajectory for prevalence overtaking other diseases



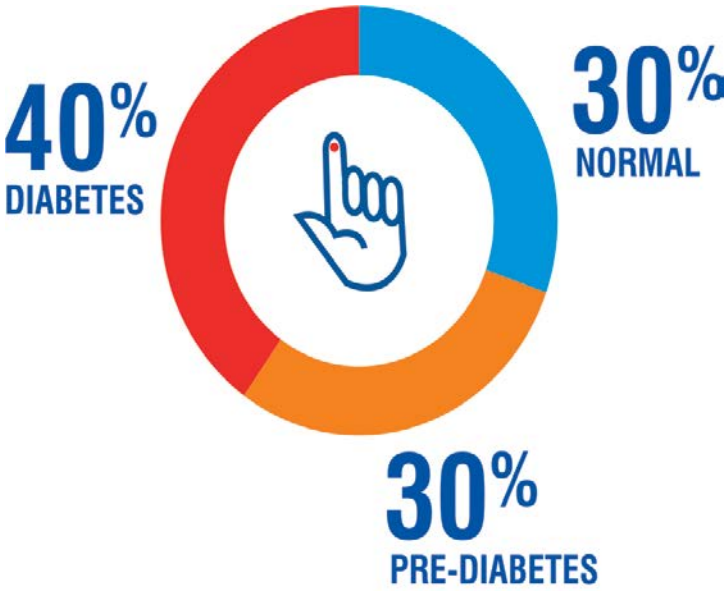
Projected Change in expenditure for Type 2 Diabetes

Western Sydney Diabetes

OUR ‘HOT SPOT’

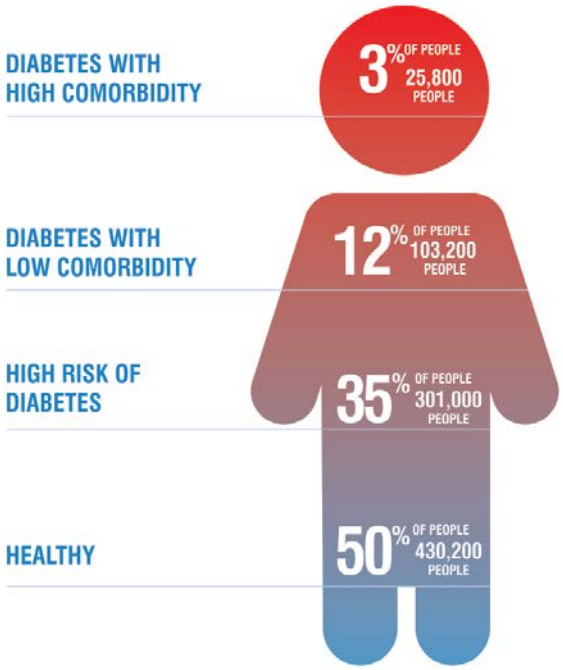

Sydney
Gosford
Hawkesbury
Hornsby
Baulkham Hills
Pittwater
Blacktown
Ku-ring-gai
Warringah
Penrith
Ryde
Willoughby
Manly
Parramatta
Lane Cove
Mosman
Holroyd
Auburn
Canada Bay
Woollahra
Fairfield
Strathfield
Marrickville
Sydney
Waverley
Liverpool
Bankstown
Canterbury
Botany Bay
Randwick
Rockdale
Hurstville
Kogarah
Campbelltown
Sutherland Shire
Wollondilly
LGA diabetes
Odds Ratio
0.5 - 0.7
0.7 - 0.9
0.9 - 1.0
1.0 - 1.1
1.1 - 1.4
1.4 - 1.8
N
0 5 10 20
Kilometres
Blacktown
0 2.5 5 10
Kilometres
Mt Druitt
0 2.5 5 10
Kilometres
Mosman
0 2.5 5 10
Kilometres

THE BURNING PLATFORM



Results of HbA1c Testing at Blacktown Emergency Department

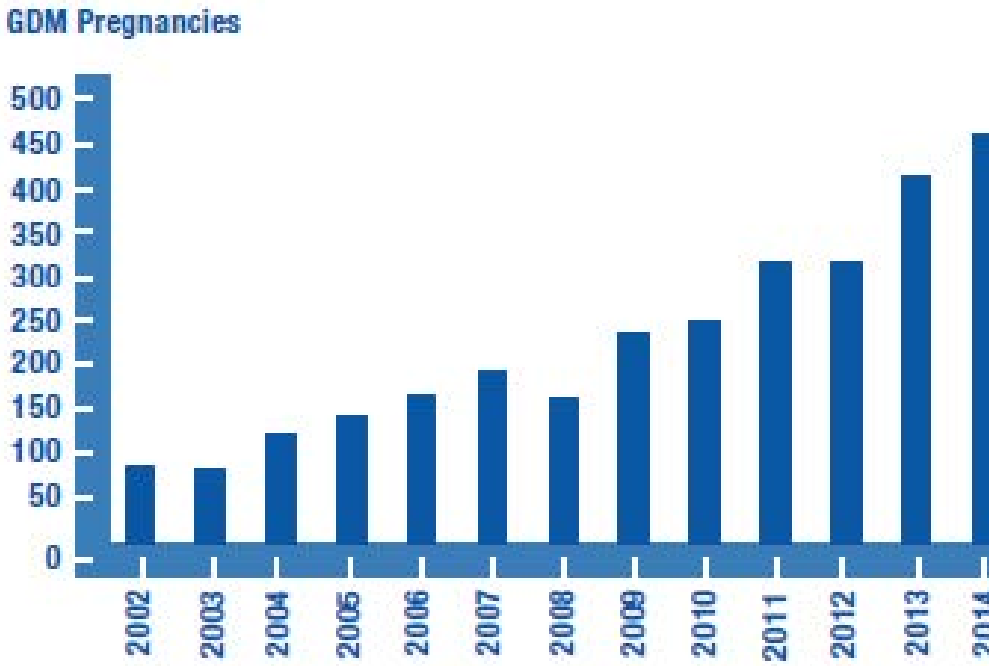
DIABETES PREVALENCE IN THE WESTERN SYDNEY COMMUNITY



AUBURN - HOLROYD - PARRAMATTA
BLACKTOWN - HILLS DISTRICT LGA'S

Western Sydney Diabetes

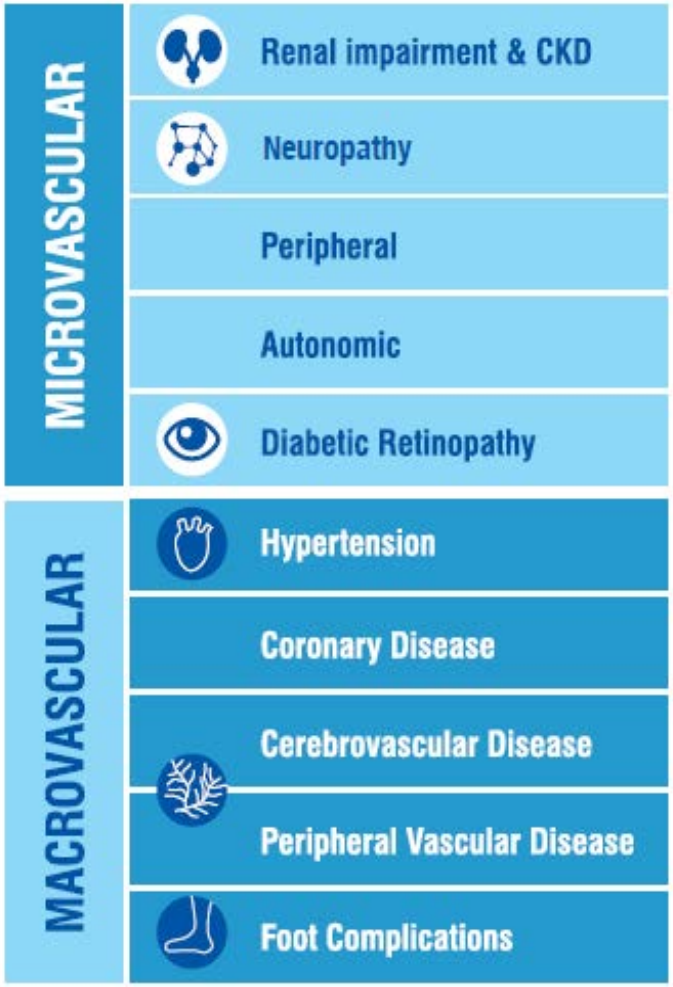
GESTATIONAL DIABETES WSLHD



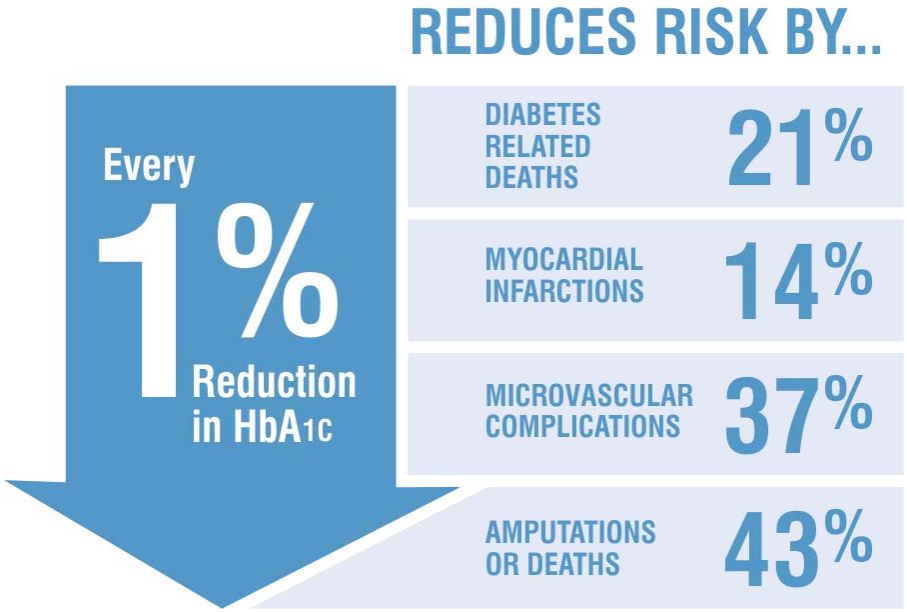
CHILDREN OF GESTATIONAL DIABETES MORE LIKELY TO CONTRACT DIABETES

30% WILL DEVELOP T2 DIABETES

DIABETES MANAGEMENT CHALLENGE



Nearly half of all Australians with diabetes have levels greater than 7%



Western Sydney Diabetes

COMMITMENT TO CHANGE

STEERING CHANGE

> *Recognising the impact of the diabetes epidemic now and in the future in Western Sydney we need a larger, comprehensive approach to stop it overwhelming our health system.*
>
> Danny O'Connor
> Chief Executive
> Western Sydney Local Health District

Western Sydney Diabetes

FRAMEWORK FOR ACTION

Prevention addressing the social determinants

More screening and lifestyle coaching

Enhanced management by GPs and community allied health

Specialised consultation and enhanced hospital care

INTEGRATED MULTI-SECTOR PARTNERSHIP APPROACH

SLOW THE PROGRESSION OF DIABETES

HEALTHY

HIGH RISK OF DIABETES

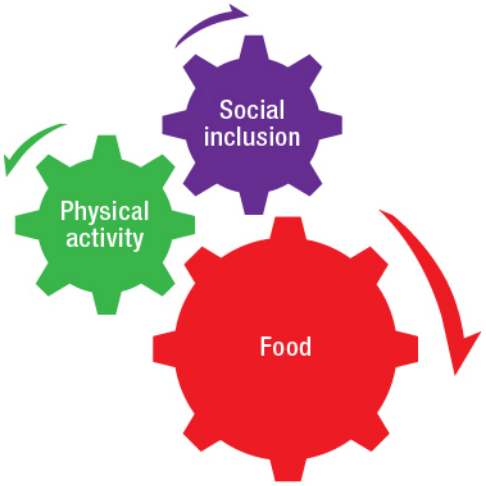
DIABETES WITH LOW COMORBIDITY

DIABETES WITH HIGH COMORBIDITY

SLOW THE PROGRESSION OF DIABETES

PREVENTION AND SCREENING

ADDRESSING THE SOCIAL DETERMINANTS



ALLIANCE UNDER THE PREMIER'S DEPARTMENT

SCREENING

IMPLEMENTING HEALTHY EATING AND ACTIVE LIVING (HEAL STRATEGY)

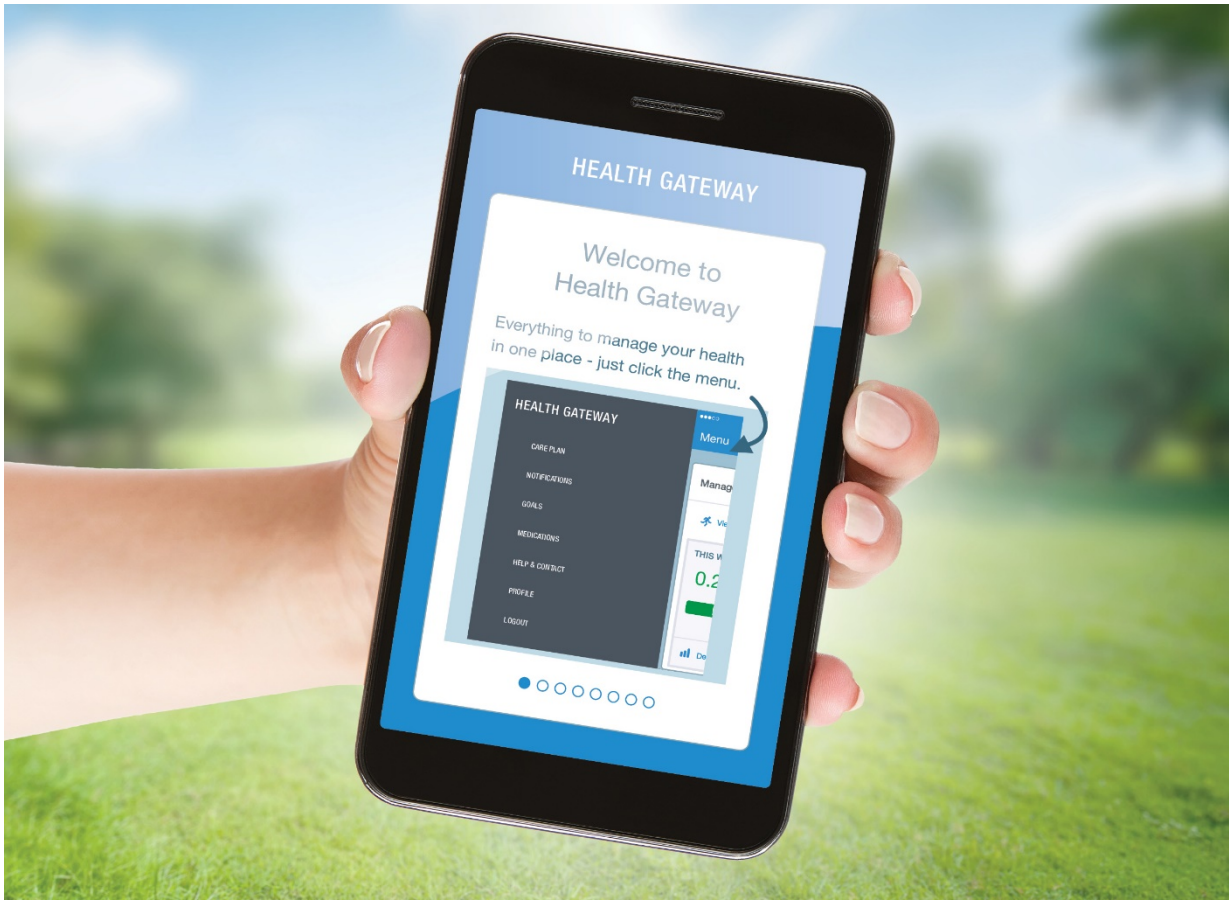
ENHANCED MANAGEMENT
BY GPs AND ALLIED HEALTH

THE FUTURE OF DIABETES SELF-MANAGEMENT

Western Sydney Diabetes Gateway

"Diabetes patients are limited in the time they can spend face to face with health professionals. In total this is estimated to be around eight hours per year. Amongst the other benefits this app will assist them to manage their condition more effectively for the remaining 364 days of the year. "

Sturt Eastwood
CEO Diabetes NSW



HEALTH

diabetes nsw

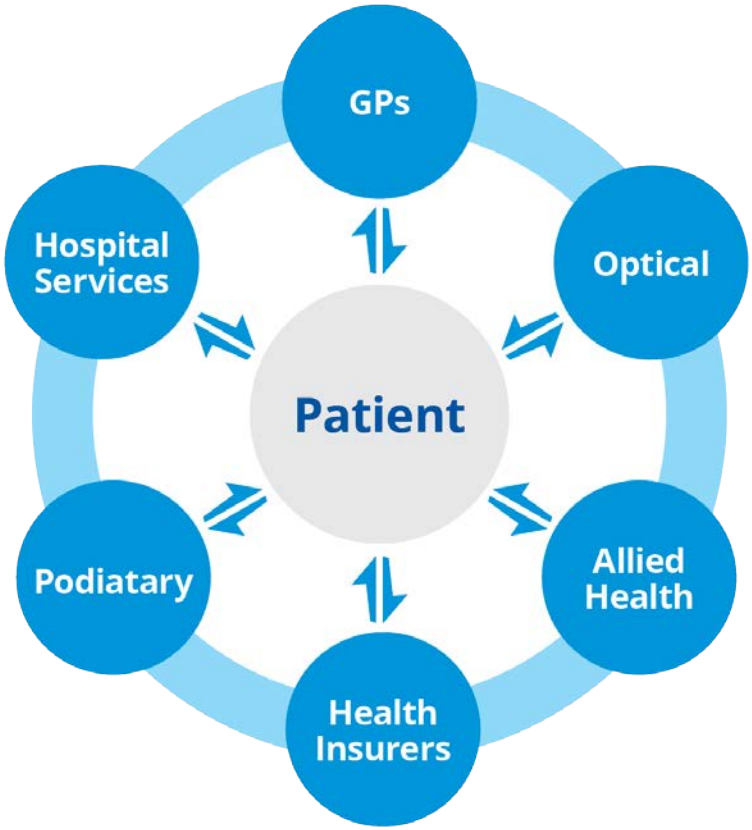
Western Sydney Diabetes

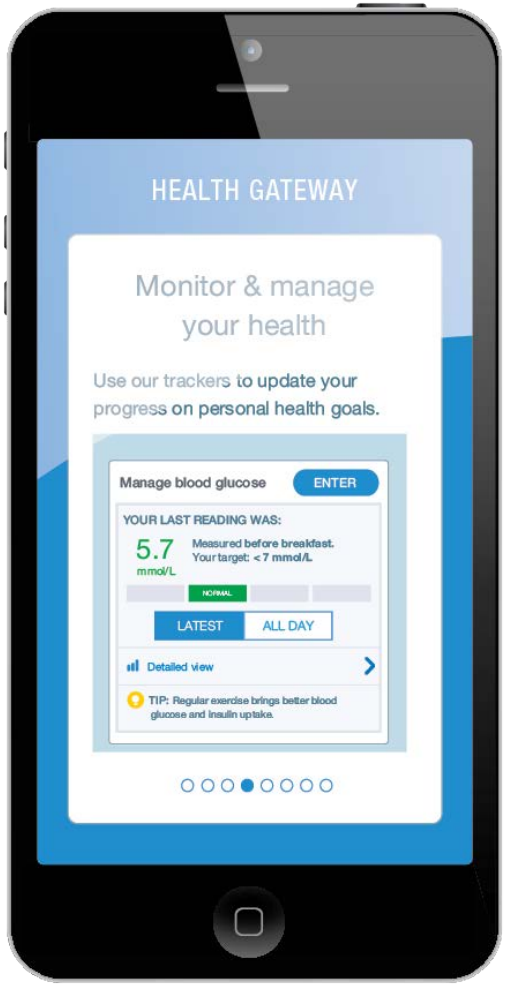
WentWest Progressing Health Now

NSW GOVERNMENT Health Western Sydney Local Health District

MANAGING THE DIABETES JOURNEY

CONNECTING PATIENTS TO THEIR CARE PROVIDERS LIKE NEVER BEFORE





The app will be developed and robustly tested with 2000 Western Sydney patients, after which time it will be made available to the wider community.

CONNECT IN ONE PLACE

- Appointment reminders
- Medication reminders
- Feedback
- Fulfil prescriptions
- Receive education
- Enhanced control

CONNECT WITH HEALTHCARE PROVIDERS

- All the patient's healthcare needs are coordinated in one place
- Patients can co-ordinate appointments with GPs and allied health providers
- GPs can monitor from desktop, complementing face to face visits
- GPs and clinicians co-ordinate care through shared data

ROLE OF COORDINATING PARTNERS

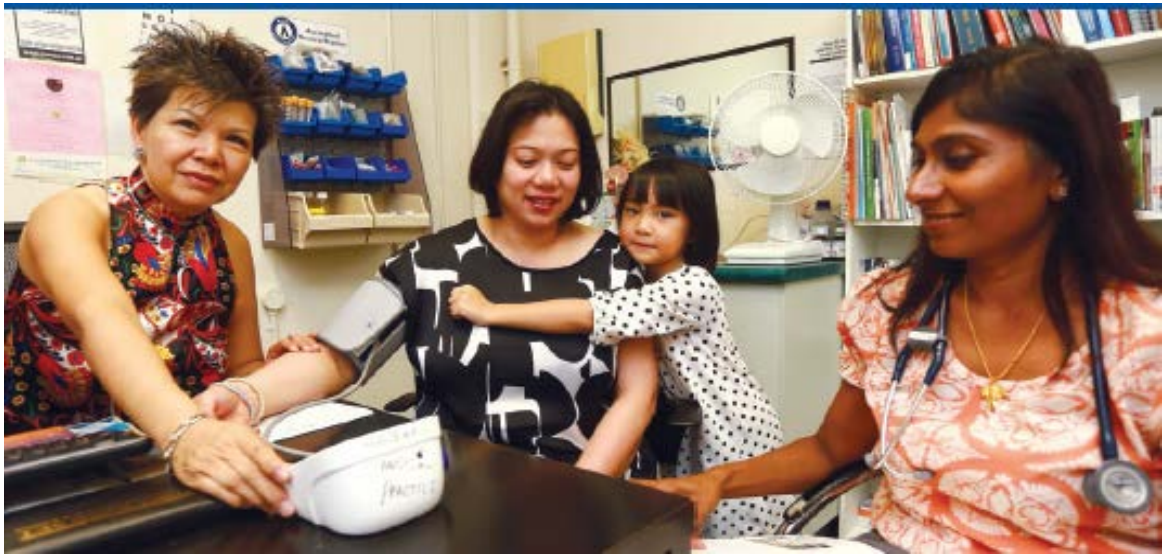
Western Sydney Diabetes	Oversee the development
HEALTH	Provision of Health Gateway core platform, web services and mobile app, including all functional components
WentWest Progressing Health Now	Provide Linked EHR interface with GP and Allied Health and General Practice support, HealthPathways
NSW GOVERNMENT Health Western Sydney Local Health District	Diabetes expertise, education, HealthPathways, evaluation, research and promotion
diabetes nsw	Peak body and convening entity for private sector, diabetes education, and promotion

CASE CONFERENCING

- ❑ 950 patients
- ❑ 105 GPs
- ❑ 38 General Practices

Early evaluation found 3-6 months post sessions, patients showed a clinically significant reduction in HbA1C (0/87%), along with beneficial effect on systolic blood pressure, weight and lipid profile.

98% of clinicians surveyed **recommend Diabetes Case conferencing** to a colleague

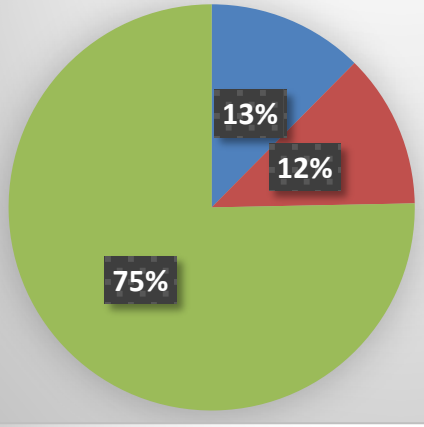


"The mere fact of discussing such complex cases with Glen (endocrinologist) proved to be invaluable. We were able to exchange ideas, Mx strategies and it was very welcoming, most of all the VIP (the patient) being included in the management was the crowning glory!"

Dr S Seelan
Bridgeview Medical Practice GP

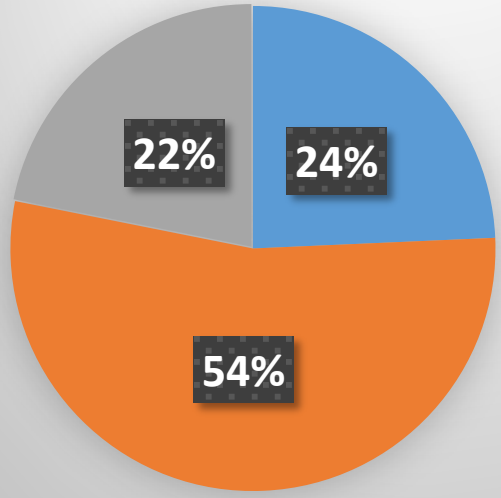
CASE CONFERENCING RESULTS

Summary of suggested management



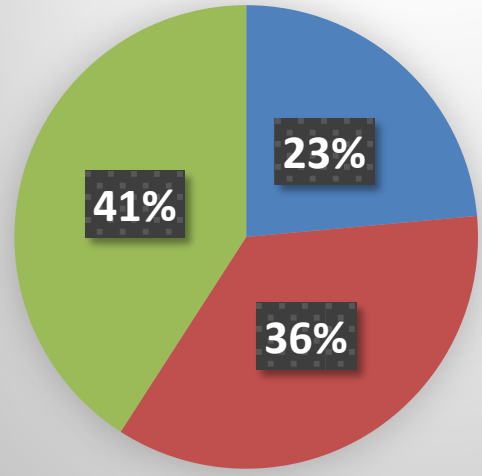
- No change
- Decrease in medication
- Increase/change in management

Breakdown of increase in management



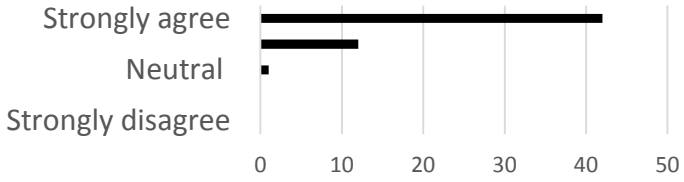
- Increase meds only
- Increase meds and lifestyle intervention
- 3 month trial lifestyle changes then review

Changes in insulin



- Reduce insulin dose
- Initiate insulin
- Increase or change insulin dose

Improved the relationship & communication between GPs & specialist



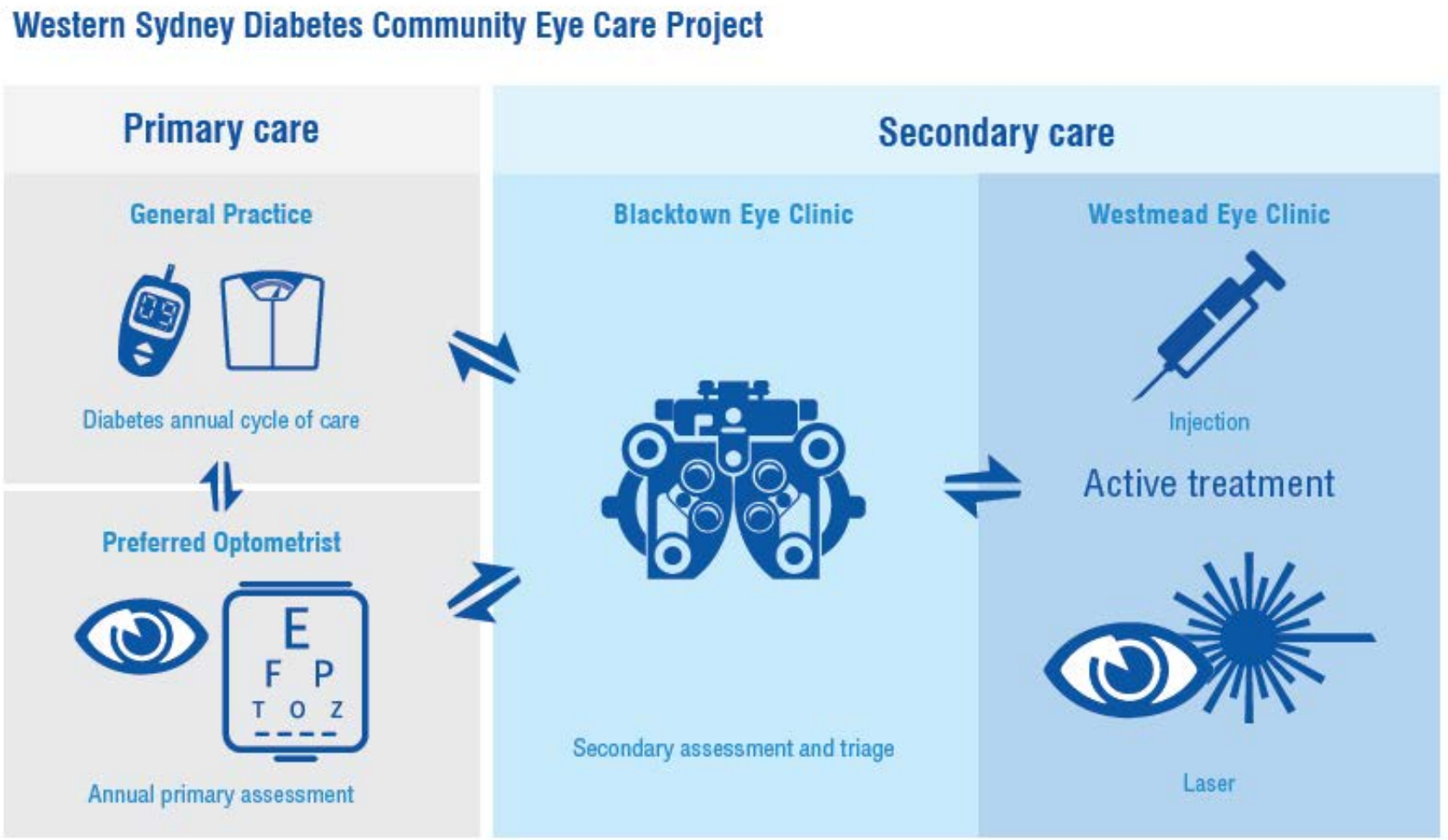
SAVE A LEG

TOP 3 SOLUTIONS FOR IMPLEMENTATION

1. DEVELOPMENT AND IMPLEMENTATION OF TWO STAGE DIABETIC FOOT SCREENING TOOL
2. PRACTICE NURSE/GP LIAISON NURSE/CHRONIC DISEASE NURSE/INDIGENOUS HEALTH WORKERS TO PROVIDE DIABETES FOOT SCREENING
3. ELECTRONIC REFERRAL TEMPLATES AND PATHWAYS

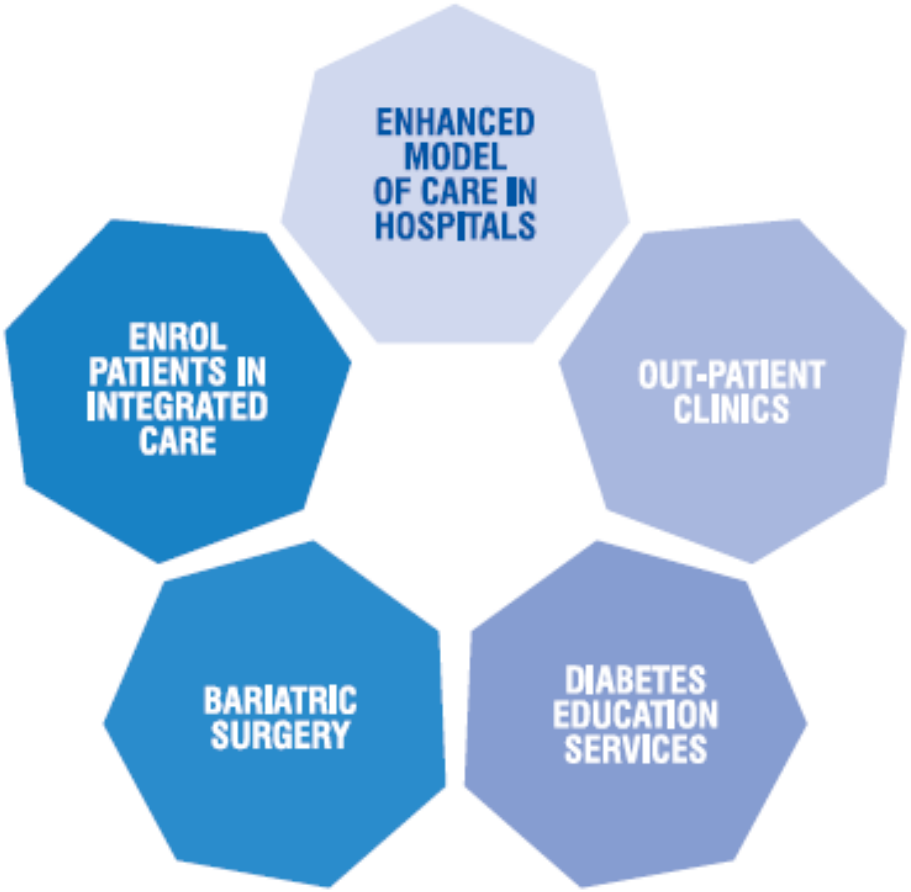
A 60 second diabetes foot screening tool was developed for general practice and patients encouraged to have foot checks at least annually. Electronic referral templates and clinical pathways were also developed to facilitate the improvement of timely access to hospital foot services

COMMUNITY EYE CARE



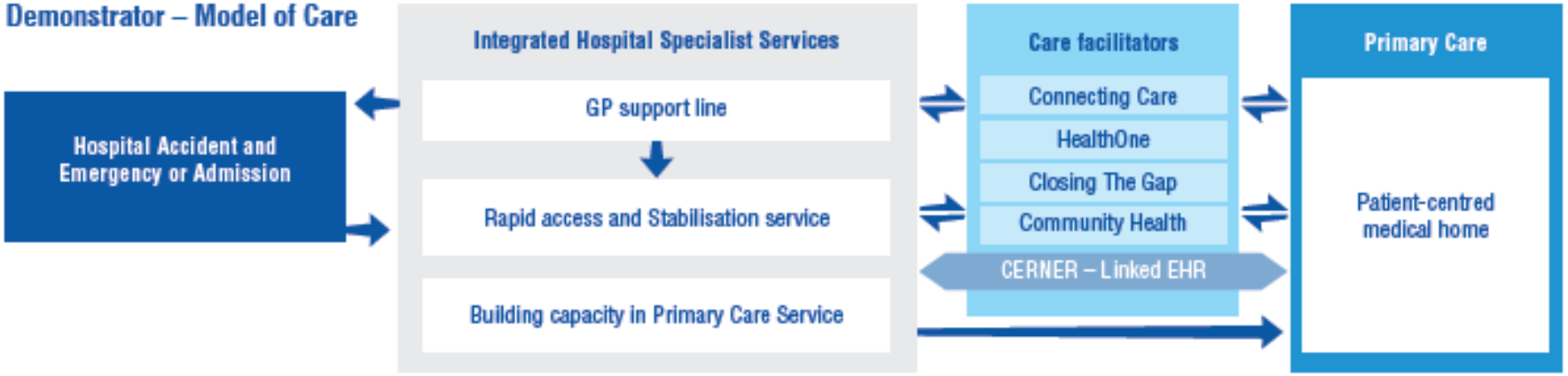
SPECIALISED CONSULTATION

AND ENHANCED HOSPITAL CARE



Enhanced model of diabetes care in hospitals:
ED, admitted and ambulatory services

WS INTERGRATED CARE DEMONSTRATOR



Key components of model:

- **Focus** on supporting Chronic Disease Management in General Practice and the Community
- Patients + GP practices **registered** for ICP
- **Disease cohorts** – COPD, heart failure, coronary artery disease, diabetes
- **Patient cohorts** – from GP and hospital
- **Dynamic Shared Care Planning**
- Whole person / **PCMH** approach
- **Care facilitators** – registered nurses supporting care planning and delivery
- **Risk stratification** – targeting the care
- **GP Support Line**
- Specialty **Rapid Access** and Stabilisation service
- **Building capacity** in Primary Care/General Practice
- **Optimising access** to Community Based Services

Supported by enablers and tools:

- HealthPathways
- Linked EHR and Cerner
- GP Support payments