PROF GLEN MABERY
Program Lead, Western Sydney Diabetes
Staff Specialist Endocrinology
Blacktown and Mt Druitt Hospitals
THE DIABETES EPIDEMIC

Overweight problem

PERCENTAGE OF AUSTRALIANS OVERWEIGHT

1995 2008 2012
56% 61% 63%

AVERAGE WEIGHT INCREASE

MEN WOMEN
3.9 kg 4.1 kg

DALY’s per 1000 population

Diabetes trajectory for prevalence overtaking other diseases

Projected Change in expenditure for Type 2 Diabetes

$7 billion

Western Sydney Diabetes
THE BURNING PLATFORM

Results of HbA1c Testing at Blacktown Emergency Department

DIABETES PREVALENCE IN THE WESTERN SYDNEY COMMUNITY

- **Diabetes with high comorbidity**: 3% of people, 25,800 people
- **Diabetes with low comorbidity**: 12% of people, 103,200 people
- **High risk of diabetes**: 35% of people, 301,000 people
- **Healthy**: 50% of people, 430,200 people

AUBURN - HOLROYD - PARRAMATTA BLACKTOWN - HILLS DISTRICT LGA'S
GESTATIONAL DIABETES WSLHD

GDM Pregnancies

CHILDREN OF GESTATIONAL DIABETES MORE LIKELY TO CONTRACT DIABETES

30% WILL DEVELOP T2 DIABETES
Nearly half of all Australians with diabetes have levels greater than 7%
COMMITMENT TO CHANGE

STEERING CHANGE

Aboriginal health
Senior health managers
Diabetes specialists
University academics
GPs
Diabetes educators
WSROC councils
Integrated care
Dept. of Premier and Cabinet
IT services
Population health
Allied health
Premiers Council for Active Living
NSW Health
Property developers

“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

- Western Sydney Diabetes Gateway
- Case Conferencing
- Save a Leg
- Health Pathways
- Community Eye Care
- LinkedEHR
- Building Practice Nurse Capacity

Supporting people with diabetes
“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
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
• 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
<table>
<thead>
<tr>
<th>ROLE OF COORDINATING PARTNERS</th>
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<tr>
<td><strong>Oversee the development</strong></td>
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<tr>
<td>Provision of Health Gateway core platform, web services and mobile app, including all functional components</td>
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<tr>
<td>Provide Linked EHR interface with GP and Allied Health and General Practice support, HealthPathways</td>
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<tr>
<td>Diabetes expertise, education, HealthPathways, evaluation, research and promotion</td>
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<tr>
<td>Peak body and convening entity for private sector, diabetes education, and promotion</td>
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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

- 75% No change
- 13% Decrease in medication
- 12% Increase/change in management

Breakdown of increase in management

- 54% Increase meds only
- 22% Increase meds and lifestyle intervention
- 24% 3 month trial lifestyle changes then review

Changes in insulin

- 41% Reduce insulin dose
- 36% Initiate insulin
- 23% Increase or change insulin dose

Improved the relationship & communication between GPs & specialist

Strongly agree
Neutral
Strongly disagree
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.
Western Sydney Diabetes Community Eye Care Project

**Primary care**
- General Practice
  - Diabetes annual cycle of care
- Preferred Optometrist
  - Annual primary assessment

**Secondary care**
- Blacktown Eye Clinic
  - Secondary assessment and triage
- Westmead Eye Clinic
  - Injection
  - Active treatment
  - Laser
Enhanced model of diabetes care in hospitals: ED, admitted and ambulatory services
WS INTEGRATED CARE DEMONSTRATOR

Demonstrator – Model of Care

Integrated Hospital Specialist Services
- GP support line
- Rapid access and Stabilisation service
- Building capacity in Primary Care Service

Care facilitators
- Connecting Care
- HealthOne
- Closing The Gap
- Community Health
- CERNER – Linked EHR

Primary Care
- Patient-centred medical home

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
- 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