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CONFERENCE ABSTRACT

The Wollondilly Diabetes Programme: A developing model of Diabetes Integrated Care

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Introduction: Diabetes costs are predominantly due to managing its chronic complications and excess hospitalisation. Optimising care reduces costs, but is challenged by limited health system integration, insufficient clinical governance and a lack of patient enablement. We ask whether integrated diabetes care, will reduce complication risk/hospital costs, and can be scalable beyond the test area.

Methods: The population of Wollondilly Shire in South Western Sydney is 46,000, of whom ~2100 have known diabetes. This rural shire has 19 'villages' with no secondary care-centres, few allied health providers, no local endocrinologist and a low GP:patient ratio (1: 2750). The Wollondilly Diabetes Programme (WDP) commenced in November 2016 and includes:

Integrated governance under the Wollondilly Health Alliance, a partnership between local government, local primary health network and local health district

Integrated clinical service and professional development through a bi-monthly clinician reference group meeting

General practice based, risk stratified, endocrinologist case conferencing (no patient attending)

Local diabetes group education

Local educator, dietitian and endocrinologist led multidisciplinary diabetes clinics

Diabetes foot screening programme

Health Pathways as a common tool for information and referral pathways

Local awareness programme

Under development:

Diabetes peer support programme (4 peer support facilitators trained)

AusCDEP, an online diabetes education tool (piloted)

Swishcare integrated electronic record development (aspects piloted)

Telemedicine clinics

Evaluation is by prospective clinical data collection and household survey, interviews and observational data.

Results: The clinical team (0.2FTE endocrinologist, 0.4FTE dietitian, 0.5FTE educator, 0.2FTE podiatrist, 0.4FTE administration), local diabetes services and pathways, case conferencing and peer support training are now in place. Primary care engagement, including both general practitioners and practice nurses, has extended to 7/9 practices participating in case conferencing, clinical referrals, practice based group education and/or clinician reference groups. Regular case conferencing now occurs (n=74, with the tools developed jointly with primary care): repeat assessments for the first 17 patients with an HbA1c >7% showed a reduction in HbA1c from $10.2\pm 2.1\%$ (pre) to $9.2\pm 1.2\%$ (post) ($p=0.008$). Attendance at 1:1 or group education was initially poor, although those that came had low knowledge. Group education attendance increased through shifting location from the local health centre to practices. Case conferencing is now extending across the district.

Discussion and conclusions: Creating a new service in a peri-urban area has been challenging for a range of financial, logistic and cultural reasons. Further observations have centred upon the financial viability of allied health, and the difficulties facing primary care in participating in joint activities when patient load is high, and local clinical practice is part time. In spite of this, key components of integrated diabetes care were able to be established and have already facilitated improved local care.

Lessons learned: Improving access to diabetes allied health does not mean their utilisation even when there is substantial need.

Limitations: Too early to evaluate in depth.

Suggestions for future research: WDP development/research will continue to focus on how all aspects of the service develop, how to extend to the wider local health district and clinical outcomes.

Keywords: diabetes; hba1c; general practice; education; integrated care
