Endocrine Network: Model of Care for People with Diabetes Mellitus

Rebecca Donovan, Endocrine Network Manager, ACI

Friday, March 21, 2014
Endocrinology Network

- Established in 2007 to improve outcomes and services for patients with endocrine disorders
- To assist clinicians to develop best practice guidelines and Models of Care
- Involves clinician consultation across care continuum
- Improve patient care
Purpose

The *NSW Model of Care for People with Diabetes Mellitus* was developed for Health Services to use as a platform for best practice of the management of type 1 diabetes, type 2 diabetes and gestational diabetes mellitus.
Key Objectives

The key objectives of the NSW Diabetes Model of Care is to ensure that diabetes services are optimally configured to:

- Improve the quality and quantity of life for people who have diabetes
- Prevent and delay the onset of type 2 diabetes
- Prevent and delay progression of diabetic complications, especially heart disease, renal failure, impaired vision and lower limb amputations
- Reduce inequities in diabetes service provision, particularly for Aboriginal people and other disadvantaged groups.
- Reduce preventable hospital admissions and Average Length of Stay for diabetes related conditions.
The Self-Assessment Tool has been developed to partner the *NSW Model of Care for People with Diabetes Mellitus*. The tool assesses the five domains outlined in the document:

- Prevention - community awareness and prevention
- Early diagnosis
- Management - optimal initial and long term management
- Complications - early detection and optimal management of complications
- Acute Episodes - coordinated prevention and management of acute episodes
# Diabetes Model of Care GP and Medicare Local Multidisciplinary and Community Health Promotion Units

The below self-assessment is designed to ascertain if there is a requirement for a high-risk foot service in your LHD. While it is acknowledged that each LHD will not require a high-risk foot service, it is necessary that people with diabetes foot disease have access to care.

## Community Awareness and Diabetic Prevention

1.  Is there a protocol/policy in your service to ensure routine screening for patients at risk of diabetes?
2.  Are you aware of health promotion programs coordinated by NGOs such as the Australian Diabetes Council?
3.  Are you aware of health promotion programs coordinated by NSW Health?
4.  Does your service refer patients at risk of diabetes to government diabetes prevention programs and NGO programs?

## Identification of High Risk People

5.  Does your centre/NL have a process for identifying high-risk groups?
6.  Does your service/NL have targeted programs for:
   - Aboriginal people
   - Children
   - High risk ethnic groups

## Risk factors

7.  Does your routine patient assessment for those newly diagnosed with diabetes at your centre/NL include the following:
   a.  Initial assessment
   b.  Chronic Disease Management Plan for management developed in collaboration with the patient
   c.  Glucose control management plan
   d.  Medication
   e.  Diet
   f.  Exercise
   g.  Does your service have a protocol/referral criteria for referral to specialist services which requires that only Type 1 diabetes, diabetes in pregnancy and patients with complicated Type 2 diabetes are referred to specialist services?

## Outpatient and Hong, Team Management

8.  Does your routine assessment for patients with diabetes include the following:
   a.  Body weight
   b.  Exercise program
   c.  Blood glucose
   d.  Blood pressure
   e.  Lipids
   f.  Smoking cessation program if required

9.  Does your routine care include individualised setting of targets/goals for:
   a.  Body weight
   b.  Exercise
   c.  Blood glucose

## ACI NSW Agency for Clinical Innovation

[ACI NSW Agency for Clinical Innovation Logo]
<table>
<thead>
<tr>
<th>#</th>
<th>Questions</th>
<th>Answers to questions</th>
<th>Action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there a space for patients to be viewed for diabetic foot complications by a co-located multidisciplinary team in the outpatient/ambulatory care setting if required?</td>
<td>B - No, patients are not able to access treatment for diabetic foot complications there and we have no mechanism for referring them for treatment at a nearby facility</td>
<td>Action 4. Your centre does not meet the minimum standards for a high risk foot service. To meet the minimum standard for a high risk foot service patients must be managed by a co-located multidisciplinary team.</td>
</tr>
<tr>
<td>2</td>
<td>Does the minimum staffing include a senior podiatrist, a nurse and a senior physician?</td>
<td>B - Sometimes</td>
<td>Action 2. The minimum staffing for a high risk foot service requires a senior podiatrist, a nurse and a senior physician.</td>
</tr>
<tr>
<td>3</td>
<td>A podiatrist is available 5 days a week as a central point of contact for urgent consultations with access to a physician during business hours</td>
<td>C - Less than 5 days per week</td>
<td>Action 8. To meet the minimum standard for a high risk foot service, the centre must have a podiatrist available at least 5 days per week for urgent consultations.</td>
</tr>
<tr>
<td>4</td>
<td>Which of the following professionals are available for consultation as needed?</td>
<td></td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>Endocrinologist</td>
<td>A - Available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wound Care Nurse</td>
<td>B - Not available</td>
<td>Action 2. Consider workforce requirements for the clinic and establish referral pathways for patients to access consultation with the required healthcare professionals.</td>
</tr>
<tr>
<td></td>
<td>Primary Care Physician</td>
<td>A - Available</td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>Diabetes Educator</td>
<td>B - Not available</td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>Dietitian</td>
<td>A - Available</td>
<td>Action 2. Consider workforce requirements for the clinic and establish referral pathways for patients to access consultation with the required healthcare professionals.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Specialist</td>
<td>A - Available</td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>Senior Clinician (Inpatient)</td>
<td></td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>The service is coordinated by a senior member of staff with expertise in the management of diabetic foot disease</td>
<td>B - No, there is not a member of the team assigned to coordinate the service</td>
<td>Action 2. It is recommended that a coordinator role be identified and recognised by the team to meet the minimum standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>Administrative Support</td>
<td>A - The service has an administrative role following clinical staff to manage the role</td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>The service is supported by administrative staff for basic tasks</td>
<td>A - The service has an administrative role following clinical staff to manage the role</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evidence Based Care</td>
<td></td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>The service has guidelines and protocols for the management of patients which are based on current evidence and best practice</td>
<td>A - Locally written guidelines and protocols are in place and are used by clinical staff</td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>Continuity of care across settings</td>
<td></td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>For inpatients, hospital staff are aware of the HRFS and refer appropriately during a patient admission</td>
<td>A - The HRFS is frequently handled by a registered staff from the hospital staff for follow-up management of patients with diabetic foot complications</td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service. Consider methods to monitor effective use of referral pathways.</td>
</tr>
<tr>
<td></td>
<td>Inpatients receive consultations not treatment from HRFS staff when appropriate, or referral from the admitting doctor</td>
<td>A - Where appropriate, all inpatients receive consultation and treatment from HRFS staff</td>
<td>Action 1. Your centre meets the best practice standards for a high risk foot service.</td>
</tr>
<tr>
<td></td>
<td>On discharge, patients are allocated an appointment at an appropriate HRFS service</td>
<td>A - On discharge, patients are given an appointment to a HRFS service (this may or may not be locally, depending on HRFS intake and patient place of residence)</td>
<td>Action 1. Your centre meets the minimum standard for a high risk foot service.</td>
</tr>
</tbody>
</table>
Opportunities for implementation

- A summary report is generated after completion of self-assessment tool
- This will outline recommend areas of need for improvement
- The summary report should be used by each health services to prioritise gaps in diabetes service care
- Once health services priorities have been completed, the ACI will work together with individual LHDs/Specialty Health Networks/Medicare Locals to develop an implementation plan.
How will it be implemented

- Health services will establish an implementation plan developed from identified priorities for diabetes care.
- The ACI team will meet with key stakeholders who are interested in implementing aspects of the Model of Care.
- Implementation plans should be developed with individual needs of LHDs/Medicare Locals in mind for the best chance of success.
Implementation team approach

- Implementation support - ACI Endocrine Network members, Manager and ACI Implementation Team
- Engagement with LHD CE’s, Managers and Clinicians
- Engagement with Medicare Local
- Covering entirety of the patient journey
- Identification of LHD contacts:
  - Existing Network members
  - Contacts already identified LHD
  - GP advisory group
Communication

The ACI team will present the Diabetes Model of Care and Self-Assessment Tool to interested stakeholders including:

- LHD Executives, hospital managers and clinicians
- ACI Endocrine Network Committee members
- Interested state-wide Executive groups
- A resource page is under development on the ACI website which includes a template for a Communication Plan and several example implementation plans
Benefits

LHDs who implement priorities identified from the *NSW Model of Care for People with Diabetes Mellitus* best practice standards may;

- Reduce re-admission rates into acute hospital settings
- Reduce co-morbidities associated with diabetes through healthy lifestyle programs promoted in the primary care sector
- Increase awareness of high risk groups at risk of developing diabetes
Evaluation

- The ACI will be developing an evaluation strategy
- Tools such as audits and surveys will be developed
- Evaluation should be a part of the implementation plan
Feedback
Contact details

Rebecca Donovan, Endocrine Network Manager
Ph: (02) 9464 4626
Email: rebecca.donovan@aci.health.nsw.gov.au

Elizabeth Bryan, Implementation Officer
Ph: (02) 9464 4714
Email: