ACI NSW Agency for Clinical Innovation

Endocrine Network: Model of Care for People with Diabetes Mellitus

Rebecca Donovan, Endocrine Network Manager, ACI

Friday, March 21, 2014

Agenda

- Endocrinology Network
- Purpose of MOC
- Key Objectives
- Self assessment
- Implementation
- Evaluation

ACI NSW Agency for Clinical Innovation

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

ACI NSW Agency for Clinical Innovation

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.

ACI NSW Agency for Clinical Innovation

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.

ACI NSW Agency for Clinical Innovation

Self Assessment tool

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

ACI NSW Agency for Clinical Innovation

Self Assessment Checklist - new1 - Microsoft Excel

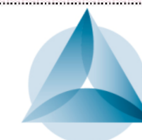
Diabetes Model of Care GP and Medicare Local Multidisciplinary and Community Health Promotion Units

Row	A	B	C
2		The below self assessment is designed to ascertain if there ia 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 diabetic foot disease have access to care.	Rating
3	1	Community Awareness and Diabetes Prevention	
4	1	Is there a protocol/policy in your service to ensure routine screening for patients at risk of diabetes?	A: Yes, there are routine letters sent to those who are identified at risk.
5	2	Is your service aware of health promotion programs coordinated by NGOs such as the Australian Diabetes Council?	
6	3	Is your service/ML aware of health promotion programs coordinated by NSW Health?	Yes
7	4	Does your service refer people at risk of diabetes to government (diabetes prevention programs) and NGO programs	Yes
8	5	Does your service provide local health promotion/healthy lifestyle/exercise programs/weight loss programs?	No
9			
10		Identification of High Risk People	
11	6	Does your centre/ML have a process for identifying high risk groups?	
12	7	Does your service/ML have targeted programs for	
13		Post GDM	
14		Aboriginal people	
15		Obese	
16		High risk ethnic groups	
17		Early diagnosis	
18	8	Does your routine patient assessment for those newly diagnosed with diabetes at your centre/ML is include the following :	
19	a	Initial assessment	
20	b	Chronic Disease Management Plan for management developed in collaboration with the patient	
21	c	Glucose control management plan	
22	d	Medication	
23	e	Diet	
24	f	Exercise	
25	9	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?	
26		Optimal Initial and Long Term Management	
27		**GP coordinated multidisciplinary management**	
28	10	Does your routine assessment for patients with diabetes include the following;	
29	a	Body weight	
30	b	Exercise program	
31	c	Blood glucose	
32	d	Blood pressure	
33	e	Lipids	
34	f	Smoking cessation program if required	
35	11	Does your routine care include individualised setting of targets/goals for;	
36	a	Body weight	
37	b	Exercise	
38	c	Blood glucose	

DM MoC questions | Summary report | Lists

ACI NSW Agency for Clinical Innovation

#	Questions	Answers to questions	Action required
	Multidisciplinary team approach		
1	Is there access for patients to be treated for diabetic foot complications by a co-located multidisciplinary team in the outpatient or ambulatory care setting if required?	D - No, patients are not able to access treatment for diabetic foot complications here and we have no mechanism for referring them for treatment at a nearby facility	Action 4: Your centre does not meet the minimum standards of 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.
2	Does the minimum staffing include a senior podiatrist, a nurse and a senior physician?	B - Sometimes	Action 2: The minimum staffing for a high risk foot service requires a senior podiatrist, a nurse and a senior physician
3	A podiatrist is available 5 days a week as a central point of contact and for urgent consultations with access to a physician during business hours	C - 1 to 3 days per week	Action 3: To meet the minimum standard for a high risk foot service, the centre must have a podiatrist available at least 3 days per week for urgent consultations
4	Which of the following professionals are available for consultation as indicated:		
	Endocrinologist	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Wound Care Nurse	B - Not available	Action 2: consider workforce requirements for the clinic and establish referral pathways for patients to access consultation with the required health professionals/teams
	Vascular Surgeon	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Orthopaedic Surgeon	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Diabetes Educator	B - Not available	Action 2: consider workforce requirements for the clinic and establish referral pathways for patients to access consultation with the required health professionals/teams
	Dietician	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Orthotist	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Psychiatrist	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Psycologist	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Social Worker	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Rehabilitation Specialist	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Indigenous Health Worker	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Infectious Disease Specialist	A - Available	Action 1: Your centre meets the best practice standards for a high risk foot service
	Senior Clinician leadership		
5	The service is coordinated by a senior member of staff with expertise in the management of diabetic foot disease	B - No, there is not a member of the team assigned to co-ordinate the service	Actions 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
	Administrative support		
6	The service is supported by administration staff for basic tasks	A - The service has administrative staff allowing clinical staff to maximise their time	Action 1: Your centre meets the best practice standard for a high risk foot service
	Evidence Based Care		
7	The service has guidelines and protocols for the management of patients which are based on current evidence and best practice	A - Locally written guidelines and protocols are in date and are used by clinical staff	Action 1: Your centre meets the best practice standards for a high risk foot service
	Continuity of care across settings		
8	For inpatients, hospital staff are aware of the HRFS and refer appropriately during a patients admission	A - The HRFS frequently receive appropriate referrals from the hospital staff for follow-up management of patients with diabetic foot complications	Action 1: Your centre meets the best practice standard for a high risk foot service. Consider methods to monitor effective use of referral pathways.
9	Inpatients receive consultation and treatment from HRFS staff when appropriate on referral from the admitting doctor	A - Where appropriate, all inpatients receive consultation and treatment form HRFS staff	Action 1: Your centre meets the best practice standards for a high risk foot service
10	On discharge patients are allocated an appointment at an appropriate HRFS service	A-On discharge, patients are given an appointment to a HRFS (this may or may not be locally, depending on HRFS intake and patient place of residence)	Action 1: Your centre meets the minimum standard for a high risk foot service



ACI NSW Agency for Clinical Innovation

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.

ACI NSW Agency for Clinical Innovation

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 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.

ACI NSW Agency for Clinical Innovation

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 Loacls
- Covering entirety of the patient journey
- Identification of LHD contacts:
  - Existing Network members
  - Contacts already identified LHD
  - GP advisory group

ACI NSW Agency for Clinical Innovation

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

ACI NSW Agency for Clinical Innovation

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

ACI NSW Agency for Clinical Innovation

Evaluation

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

ACI NSW Agency for Clinical Innovation

Feedback

ACI NSW Agency for Clinical Innovation

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: