INTEGRATED HEALTHCARE

Diabetes alliance integration project
Hunter New England Local Health District

Challenge
There is an escalating prevalence of diabetes and its complications, and there is the imperative for high quality clinical care. This situation is intensified in the Hunter New England Local Health District by the geographical spread of our patients with diabetes (60,000 patients across 131,000km²). Improvements to primary care are an integral part of building responsive, efficient, and sustainable health care. The challenge is to design a new model of care that will strengthen primary care, integrate primary and tertiary services and overcome inertia to truly change the diabetes landscape.

Solution
The Alliance Diabetes Integration Project is a proof of concept pilot. General practices were offered case-conference style consultations within each practice attended by an endocrinologist, diabetes educator, general practitioner, practice nurse and patient. This provided a holistic approach to care, delivering intensive individualised education for all involved. Recommendations were implemented by their usual general practitioner without specialist clinic follow-up. Practice staff could then offer standardised high quality care to their remaining patients with reduced specialist input.

Results
20 practices and 496 patients were seen over 14 months. A six month follow-up of 147 patients showed there was significant improvement in parameters including HbA1c, weight, cholesterol, and blood pressure. All of the involved clinicians felt the experience was “satisfying” or “very satisfying”. Patients reported feeling empowered and supported with 34 per cent reporting improved knowledge and confidence using the validated Patient Activation Measure. A diabetes registry is also concurrently being established to further improve outcomes.

Acknowledgements: