

CONFERENCE ABSTRACT

Diabetes Alliance in the Hunter and New England region

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The Hunter New England Local Health District (HNELHD) has 80,000 persons living with diabetes. Demand for public specialist care has been increasing annually resulting in long waiting times and inequity of access due to geographical location.

A review of patients accessing publically funded tertiary diabetes care revealed that many patients could be managed by primary care clinicians, thus freeing tertiary services for complex patients. Primary care clinicians reported a lack of confidence providing best evidence care due to the rapid expansion in knowledge and therapeutics options for diabetes.

The Diabetes Alliance was developed to overcome barriers to providing care in the general practices. This required partnerships between health organisations with different priorities, funding and reporting structures. The new model of care involves endocrinologists and diabetes educators working with general practitioners (GP) and practice nurses (PN) in the GP practice with the primary objectives of improving knowledge, confidence and skills. Practices are offered 2-3 days of case conferencing with 10 patients/day followed by brief visits at 6 and 12 months. The model incorporates data driven education and quality improvement support through partnership with the NPS MedicineWise MedicineInsight program.

The target population are GP practices within HNELHD. The patient population is >18 years with Type 2 diabetes (T2DM), HbA1c >53 mmol/mol, not actively receiving diabetes care privately.

Stakeholders include Hunter New England Local Health District, Hunter and Central Coast Primary health network, NPS MedicineWise, tertiary diabetes teams, primary care clinicians and patients.

The pilot project commenced in 2015, but overwhelming primary and tertiary clinician support of the program has ensured policy changes required have been readily endorsed allowing the program to be scaled up efficiently and sustainably into an ongoing program.

The program has broken down geographical, financial and traditional barriers between primary and tertiary care. By integrating and providing care in locations close to and trusted by the

patient, the program has improved access to specialist care whilst simultaneously upskilling GPs to provide better care to all patients.

The MedicinesInsight reporting allow practices to identify, stratify and actively manage patients as well as providing a mechanism to monitor agreed quality improvement goals. Reporting also allows the Alliance partner administrators to allocate resources effectively.

From May 2015 to June 2017, 830 patients have been seen in 50 GP practices. Did not attend rates is 3% compared to 22% in hospital based diabetes clinics. Preliminary data has demonstrated statistically significant improvement in HbA1c, weight, total cholesterol and systolic blood pressure.

This integrated model of care can be applied to many chronic diseases. Although originally founded in metropolitan Newcastle it has since been rolled out to rural and remote practices including Aboriginal Medical Services.

The Alliance has demonstrated the benefits of integrating care between primary and tertiary clinicians for patients with T2DM for both the individual patient and

the health system as a whole. Through integration, the model has improved trust

between clinicians and sharing of data has allowed improvement in identifying

health needs across the district as well as providing a basis for local quality

improvement in GP practices.

Keywords: integration; trust; data sharing; upskilling
