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Conference Abstract

# Possibilities in diabetes service integration – consumers informing changes to local service delivery

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## Abstract

**Introduction/Background:** Studies suggest that diabetes prevalence will rise to exceed 10% of the Australian population by 2030, which in our district, would equate to over 80,000 cases. Current estimates in South Eastern Sydney Local Health District (SESLHD) for 850,000 people suggest that when undiagnosed cases are included this is over 60,000 people or 7.6%. The number of women developing gestational diabetes has also doubled over the past decade. There are 60 residents with diabetes co-morbidity hospitalised every day and people admitted with diabetes co-morbidity cost the district $65 million dollars annually. Locally, Type 2 diabetes accounts for approximately 80% of all cases, Type 1 approximately 16%, Gestational approximately 3%, and the remainder classified as 'Other Types' <1%.

**Methods:** The Integrated Diabetes Project Steering Committee was funded to use Clinical Redesign methodology to investigate the problems and decided upon the establishment of four working groups for the diagnostic phase of the project. These were: Transitional Diabetes (Paediatric to Adult Service Transition), Gestational Diabetes, Type One Diabetes and Type Two Diabetes. Key stakeholders included clinicians internal and external to SESLHD and Medicare Locals engaged in issues identification. The groups also had external Diabetes organisation input from the local consumers in focus groups and surveys, Diabetes Council NSW and Juvenile Diabetes Research Foundation. Consumer input has been planned with a variety of methods used.

Improvement Realized

**Implementation comprised:**

•Increasing primary care support, management and care integration of type two diabetes-establishing diabetes educator across Medicare Locals and primary care setting with strong links to SESLHD

•Service Descriptor Development of Diabetes Services across Southern Sector (including TSH and STG Diabetes Services, Medicare Locals, primary care and community services), Triage category development and pathway mapping and development

•Establish sustainable programs for early education of newly diagnosed non complex patients with diabetes in systematised format and offered with bilingual workers as required

•Shared directory of service delivery information for patients and practitioners -Contemporary service descriptors linked via web sites

**Results:** A strong consumer view from focus groups and community engagement resulted in a trend towards more tailored community diabetes education. Implementation is ongoing with changes to optimise diabetes patient management across main areas underway. Lifestyle management programs offer large savings (see Table 1) with over 25,000 cases to be prevented with earlier screening and management - with over 16 million dollars saved each year over the next 20 years.

**Conclusions:** The key issues to change with high SESLHD influence and of high impact were integrated electronic records management, improved service reporting, standard funding and billing, the need for more integrated pathways for primary and tertiary care, the lack of multidisciplinary care provision, the need for improved information technology capabilities with meters and timely pathology result dissemination and improved communication with primary care. An integrated model of diabetes management that screens people earlier is requested by consumers and introduces a standardised lifestyle program that allows responsibility to be shared for management according to accepted pathways and known referral and escalation relationships is underway. Responsibility can then be shared between patients and their families, health service practitioners and primary health care providers.

## Keywords

**diabetes integration; consumer; shared management**

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## PowerPoint presentation

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