
CONFERENCE ABSTRACT

Stepping Up Implementation Project

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Introduction (context and problem statement): Most people with type 2 diabetes have their clinical care based in primary care, where evidence-based clinical management can help achieve target levels for glucose levels (glycaemia). However, many people remain out of glycaemic target range, leading to downstream vascular complications. Optimising glycated haemoglobin to minimise risk of long-term complications among people with type 2 diabetes is a global priority. Supporting timely treatment intensification, particularly insulin initiation, through innovation in primary care could have a major impact.

Short description of practice change implemented: The project is based on the original Stepping Up randomised trial in general practice which found that with appropriate support and reorientation of roles, General Practitioners and Practice Nurses can manage commencement of insulin as part of routine care of people with Type 2 diabetes in their general practices.(1) For this project, two Registered Nurse Credentialed Diabetes Educators based in community health are trained to undertake mentoring roles supporting Practice Nurses in their areas to play a more active role in the initiation of insulin and other injectable therapies in General Practice.

Aim and theory of change: The Stepping Up Implementation project is a community and primary-care led approach to integrated care that is seeking to build the capacity of general practice in the north western Melbourne region to better manage the intensification of diabetes treatment in the community. Our approach to professional behaviour change was informed by Normalisation Process Theory and developed through pilot studies.

Targeted population and stakeholders, timeline: The project is a collaboration between North Western Melbourne Primary Health Network, the University of Melbourne Department of General Practice, Merri Health, cohealth, and the Royal Melbourne Hospital. Having commenced in May 2017, the project is seeking to implement the model of care in 20 general practices in inner north western Melbourne by June 2018.

Innovation, Impact and outcomes: It is anticipated that enabling primary care practitioners to work to their full scope will make better use of resources and provide patients with more timely local care. Additionally, the role of community health staff will build linkages between general practice and community health. Greater integration driven by this stronger relationship may offer access to a range of services offered in community health that is currently elusive to many patients.

Conclusion, Sustainability and transferability: There is opportunity to scale-up the number of general practices participating and potential to transfer the project to other community health organisations.

As a practice-nurse led model, the enhanced capacity built through mentoring is self-sustaining and utilises existing funding streams available through the Medicare Benefits Scheme. The sustainability of the mentoring element of the project is reliant upon the commitment of funding for the CDE position, which, while not assured, could be justified by the benefits of increased integration.

References:

1- Furler J, O'Neal D, Speight J, Manski-Nankervis JA, Gorelik A, Holmes-Truscott E et al. Supporting insulin initiation in type 2 diabetes in primary care: results of the Stepping Up pragmatic cluster randomised controlled clinical trial BMJ 2017; 356 :j783

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