

Diabetes Co-management in General Practice

Partnerships in Health

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Team Leader - Diabetes Co-management

Project background

- DHS HARP 2002-03 funding to Melbourne Division of General Practice
- Consortium of 5 Northern & Western Divisions of GP, Diabetes Australia Vic, Royal Melbourne Hosp.
- Mainstreamed as part of Partnerships in Health HARP CDM consortium July 2006

Partnerships in Health



Prior learnings

- Preceded by DHS Nurse Practitioner Demonstration Project which reinforced
 - GP capability for care coordination & clinical management but capacity limited by several factors
 - RN CDE capability for care coordination & clinical management but capacity limited by several factors
 - Many complex patients in general practice not accessing other services

DCGP Principles

- RN CDEs working within general practices
 - Collaborating with GP, consistent messages
 - Accessing patient history and record
 - Supporting GP processes & systems
 - Additional capacity to coordinate care and liaise with other providers
 - Implementing best practice clinical management
- Accessible service for patients with adequate education and self management support

DCGP Core Team

Working together to improve clinical management and care coordination within general practice and with the larger health system

Identify gaps in health care and respond appropriately



Target patients

- Adults with Type 1 or Type 2 Diabetes previous history of hospitalisation or at risk
- Factors that may indicate at risk of hospitalisation are one or more of:
 - History cardiovascular disease
 - Diabetes diagnosis ≥ 15 years
 - Microalbuminuria
 - 2+ high risk foot factors
 - HbA1c $\geq 9\%$

Recruitment & Assessment

- Patients are identified for screening by GP referral or review of practice population
- Comprehensive assessment by RN CDE of factors impacting on outcomes including:
 - Diabetes complication screening & targets
 - Co-morbidities
 - Self management skills
 - Psychosocial issues
 - Access to other services

Core components as required

Enhanced patient education

- One to one education and self management support
- Tailored to individual social, cultural, environmental issues
- In collaboration with GP and overall context of health care and issues

Supporting general practice systems

- Information management for systematic screening and disease management
- Proactive follow up and review

Components cont'd as required

- **Consistent Evidence Base Care**
 - Reinforcing evidence based practice
 - More aggressive and proactive management
 - Extending care in general practice & role of RN CDE e.g. insulin stabilisation, wound dressings, foot assessment
- **Coordination and liaison**
 - Single point of entry and referral to health system
 - Enhanced care coordination by GP & RN CDE
 - Enhanced liaison and continuity of care with other providers
 - Telephone advice & support by RN CDE

Component cont'd as required

Enhanced access

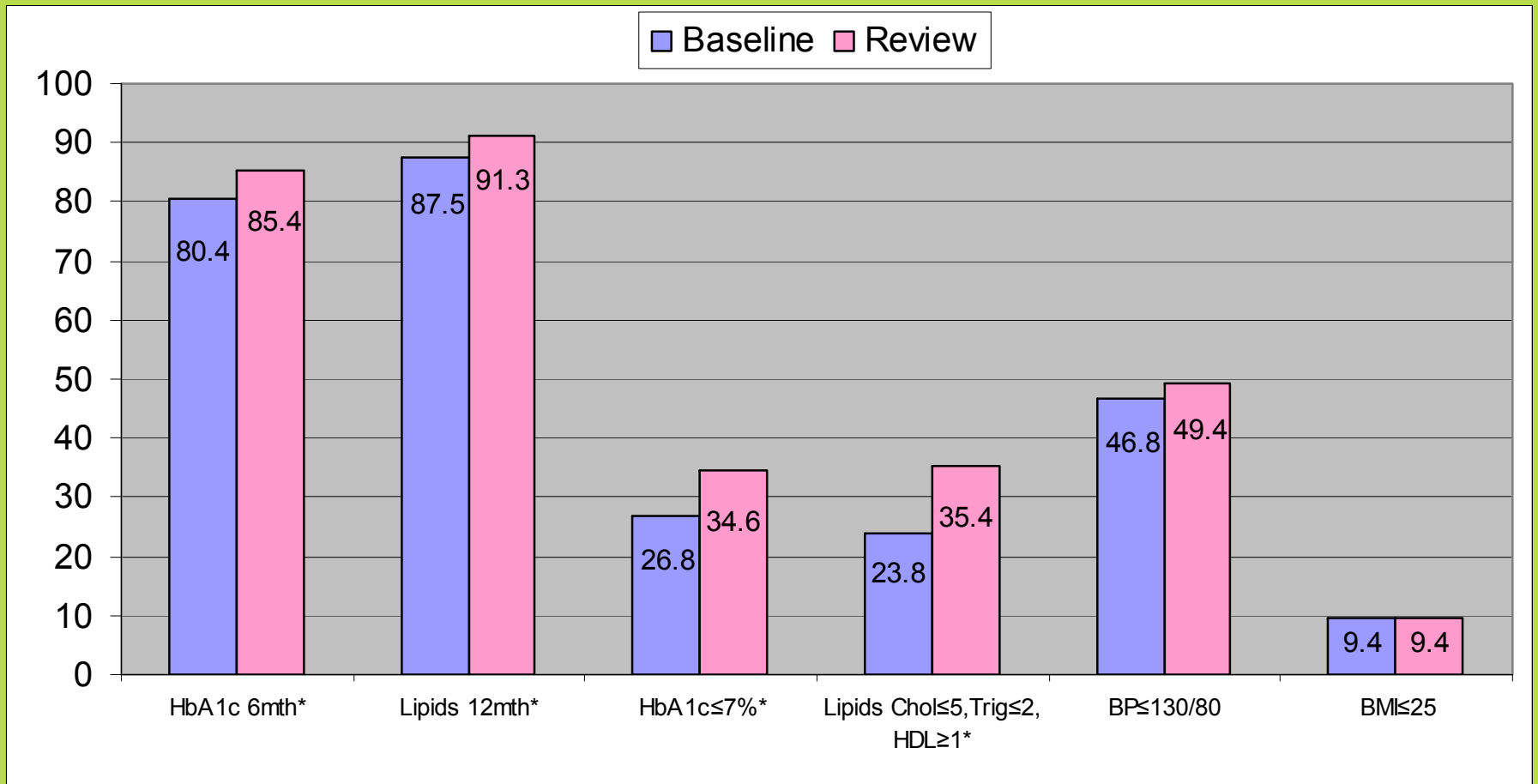
- Home visits
- Interpreters & multilingual information
- Marginalised communities

Patient characteristics

Patients recruited	1855
Patients exited (Reasons recorded - 49.5% low risk, 11.8% moved/changed GP, 9.2% refused care, 3.3% deceased, 1.6% other services)	644
Male	52.3%
Average age (range)	63.4 (20-91)
Original dataset items (of 1278 patients)	
Receiving government support/benefits/pension	78.5%
Education - Primary or less / Secondary or less	53.0 / 92.6%
Non English background / Language other than English at home	62.7 / 39.4%

Diabetes guidelines

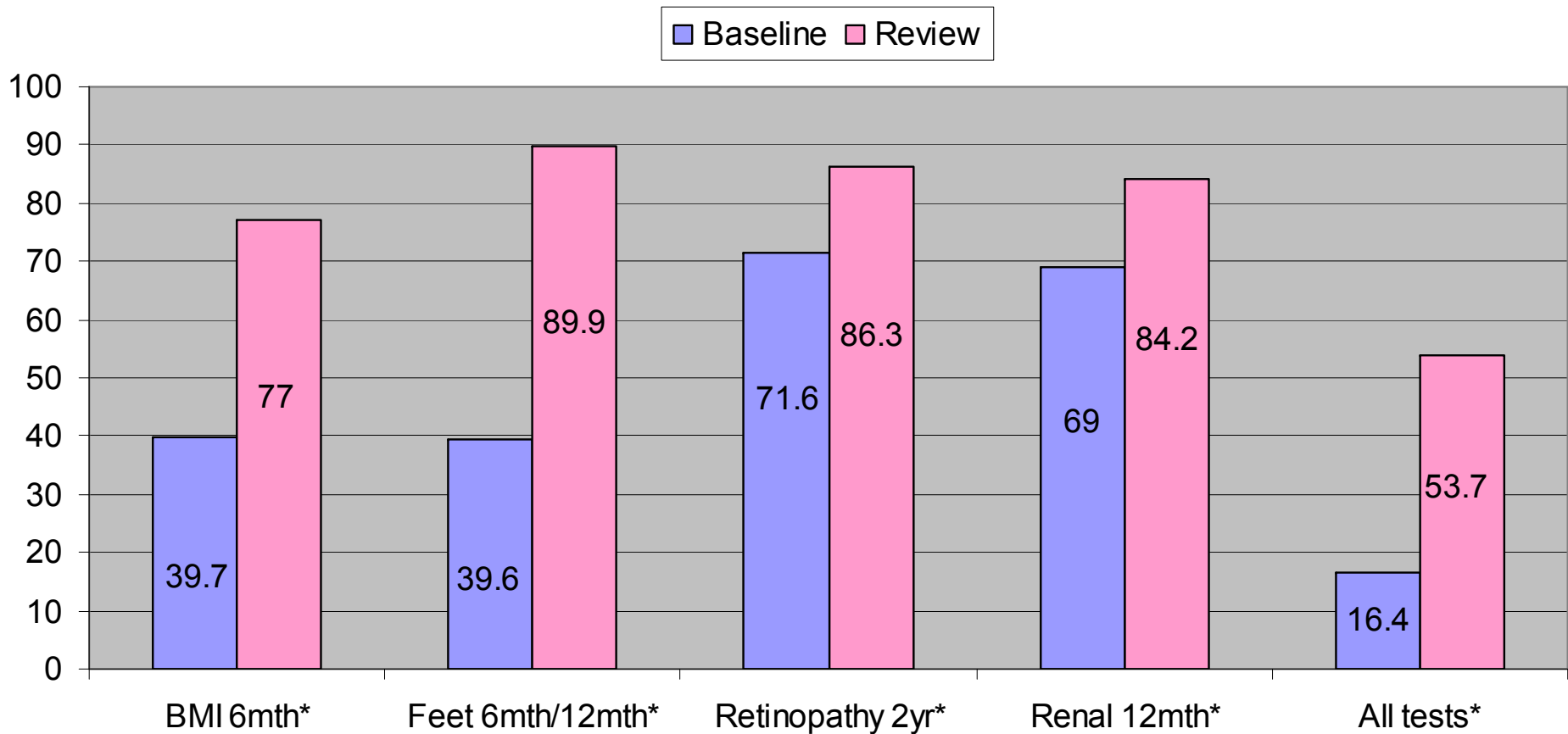
% meeting guidelines at baseline and 12 month review, ongoing data collected n=745



* Statistically significant, McNemar's Chi squared $p \leq 0.05$

Diabetes guidelines

% meeting guidelines at baseline and 12 month review, original dataset n=335



* Statistically significant, McNemar's Chi squared $p \leq .05$

Unscheduled contacts

- 663 unscheduled contacts Sep 2002 – May 2006
- In 9% of contacts patients indicated they would have gone to emergency without support
- In 10% of contacts patients would have acted inappropriately without support (e.g. missed medication, done nothing, waited to see GP)

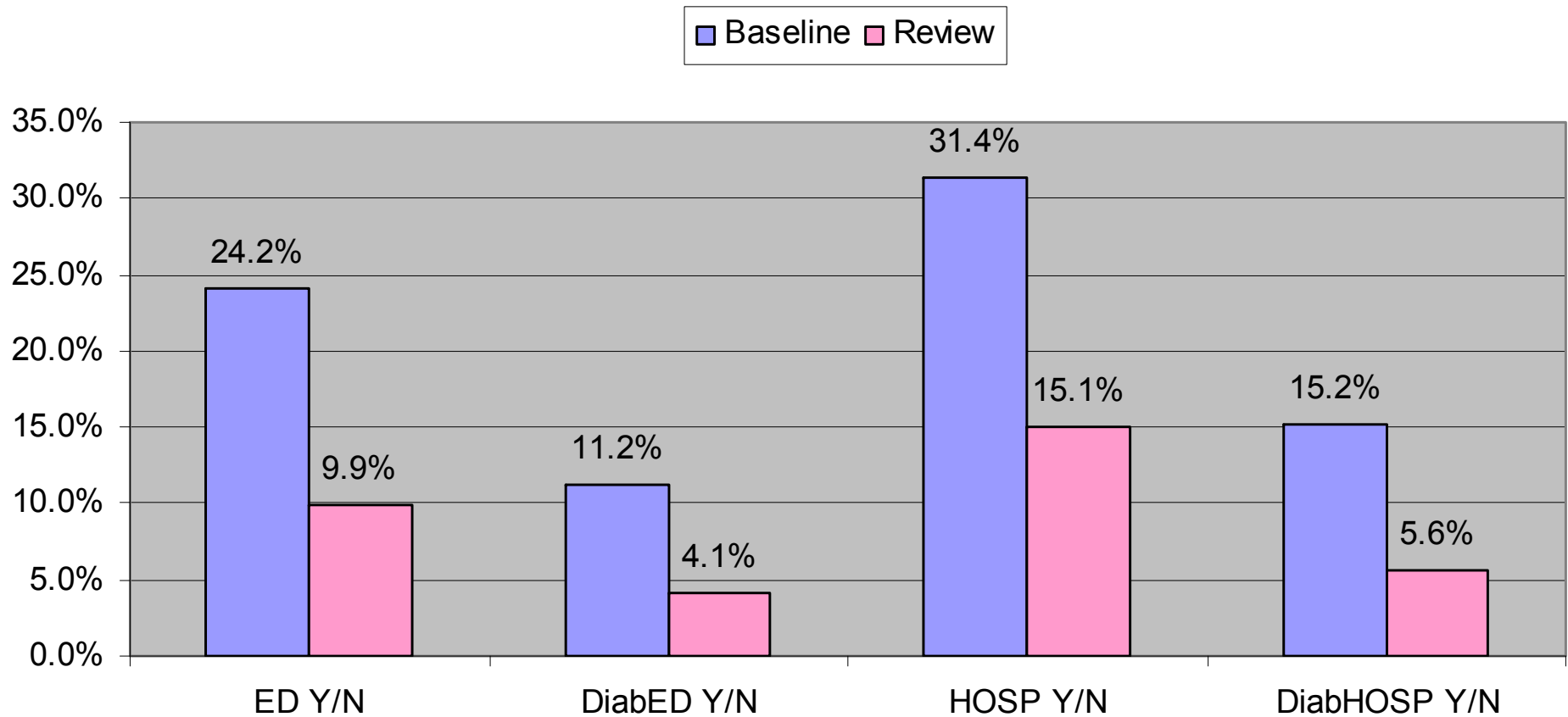
Hospital contact data definitions

Diabetes related hospital contact

- History of cardiovascular disease
- High risk diabetic foot
- Infections
- Glycaemic control
- Microvascular disease

Hospital contact

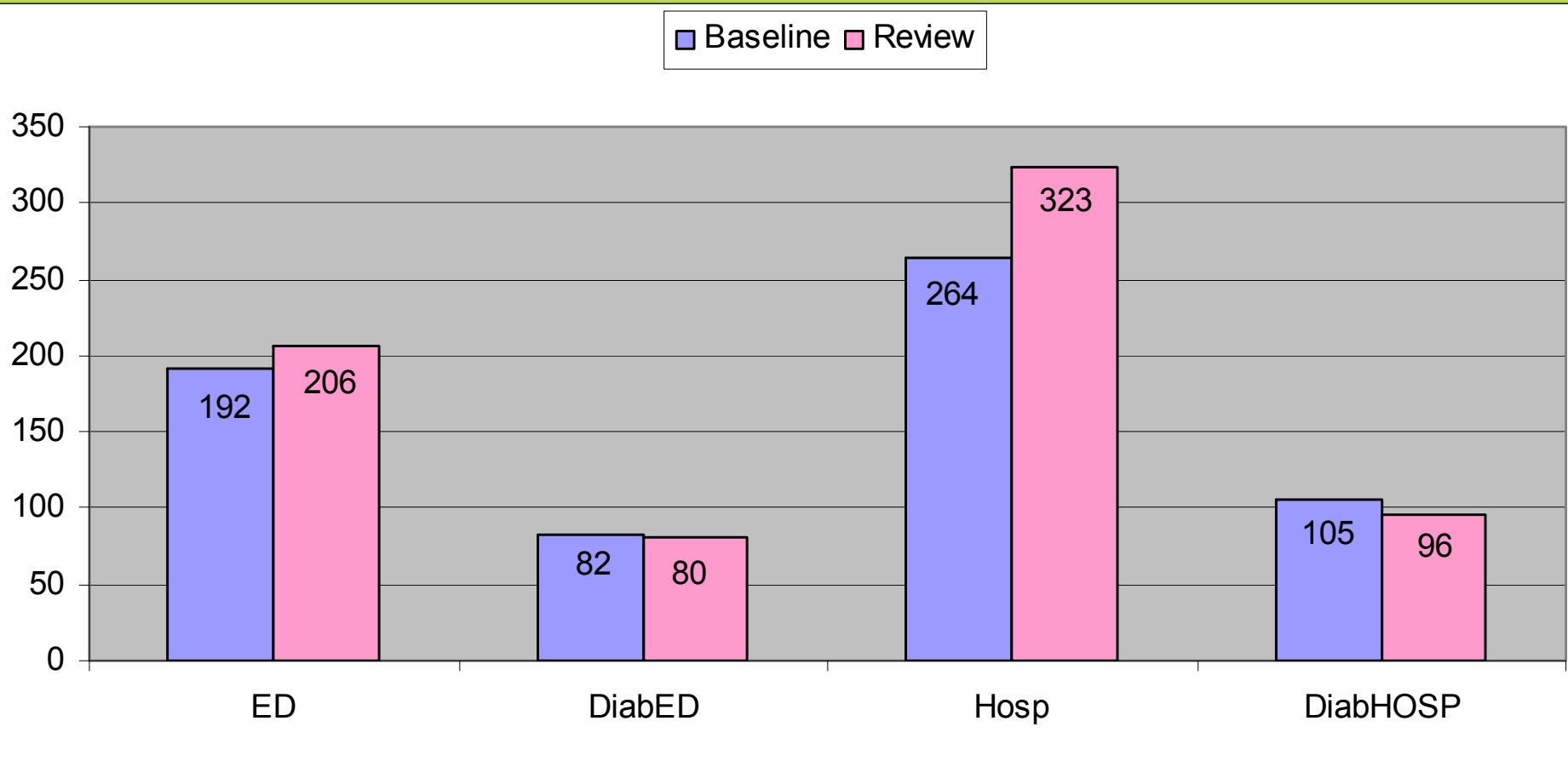
% at baseline and 12mth review for all contact & diabetes related



* All statistically significant, McNemar's Chi squared $p \leq .05$

Rate of all and diabetes related hospital contact

Rate per annum per 1000



Future directions

- Developing integrated service with Partnerships in Health HARP CDM
- Provide more regional service for complex patients in Northern and Western areas
- Expand GP engagement with other services

Contact Details

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Partnerships in Health

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