



Restoring Health Program Diabetes Model

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St Vincent's

*Continuing the Mission of
the Sisters of Charity*

Restoring Health...



- HARP February 2003
- 3 target conditions under one umbrella:
 - Heart failure, lung disease, diabetes
- St Vincent's Hospital & partner agencies
 - *Darebin Community Health*
 - *Inner East Community Health*

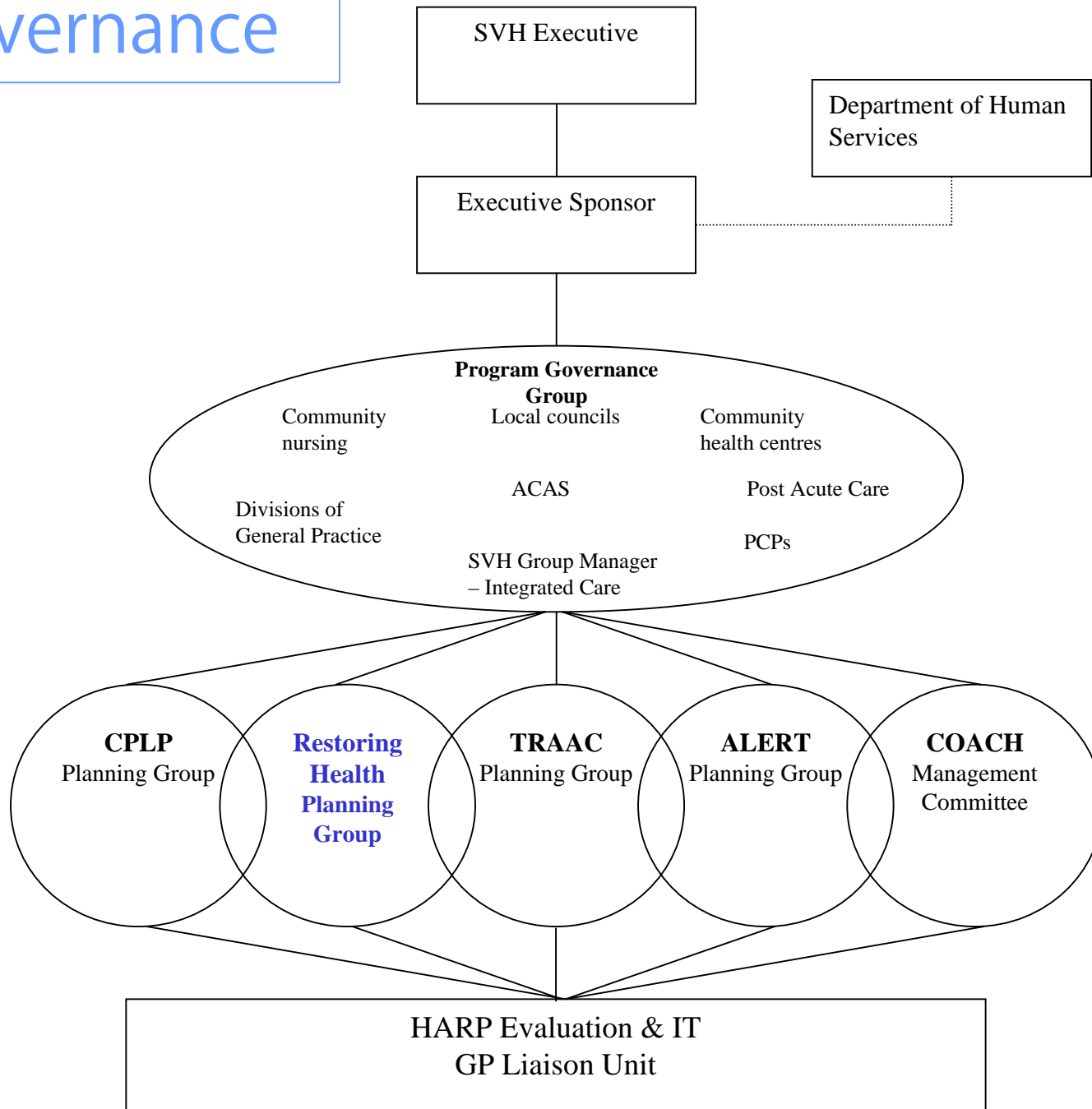


Restoring Health Program

Inner East Community
health service



Governance



Staff and EFT

Acute

- Program manager 1.0
- Clinical Coordinator 1.0
- Contact Liaison 3.0
- Heart failure CNC 0.4
- Diabetes CNC 1.0
- Allied health assist 1.0
- Admin 1.0

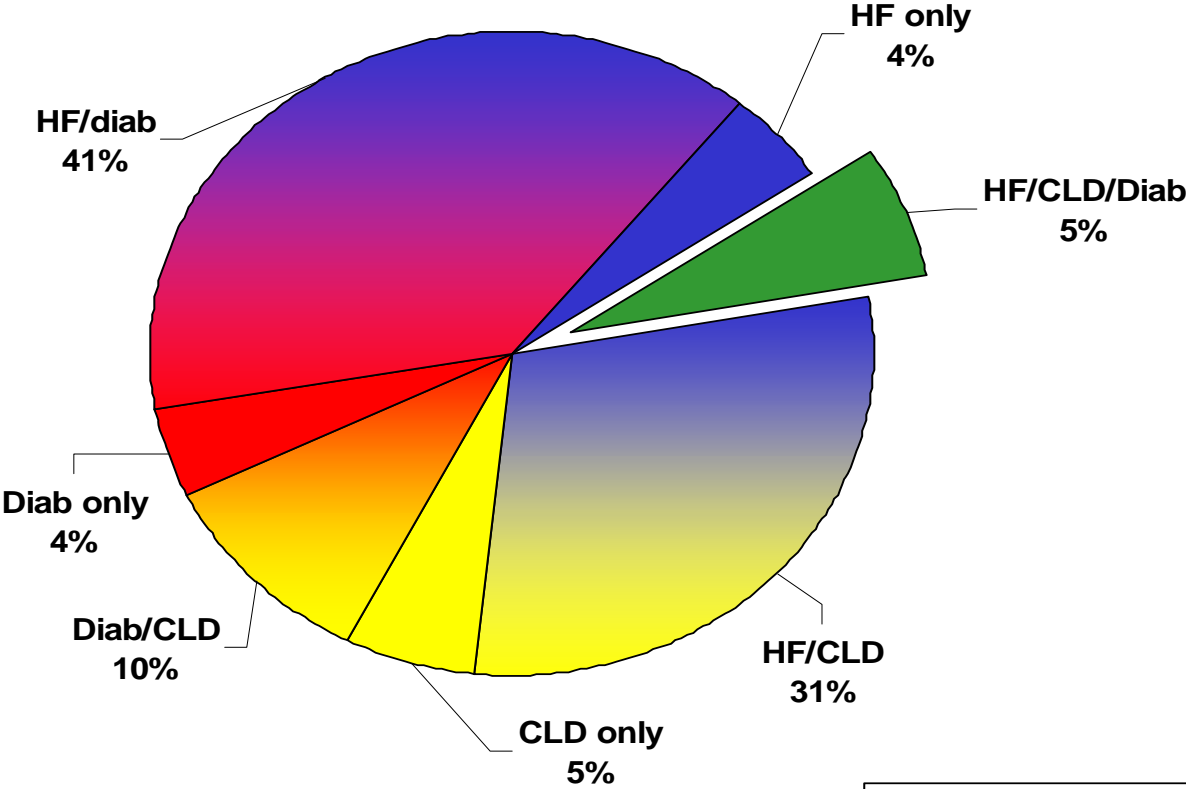
Community

- Community RN 2.0
- Dietician 0.8
- Physiotherapist 1.0
- OT 1.0
- SW 2.0
- Clinical psych 0.6
- Speech pathology 0.8
- Pharmacist 2.0

An 'at risk' population

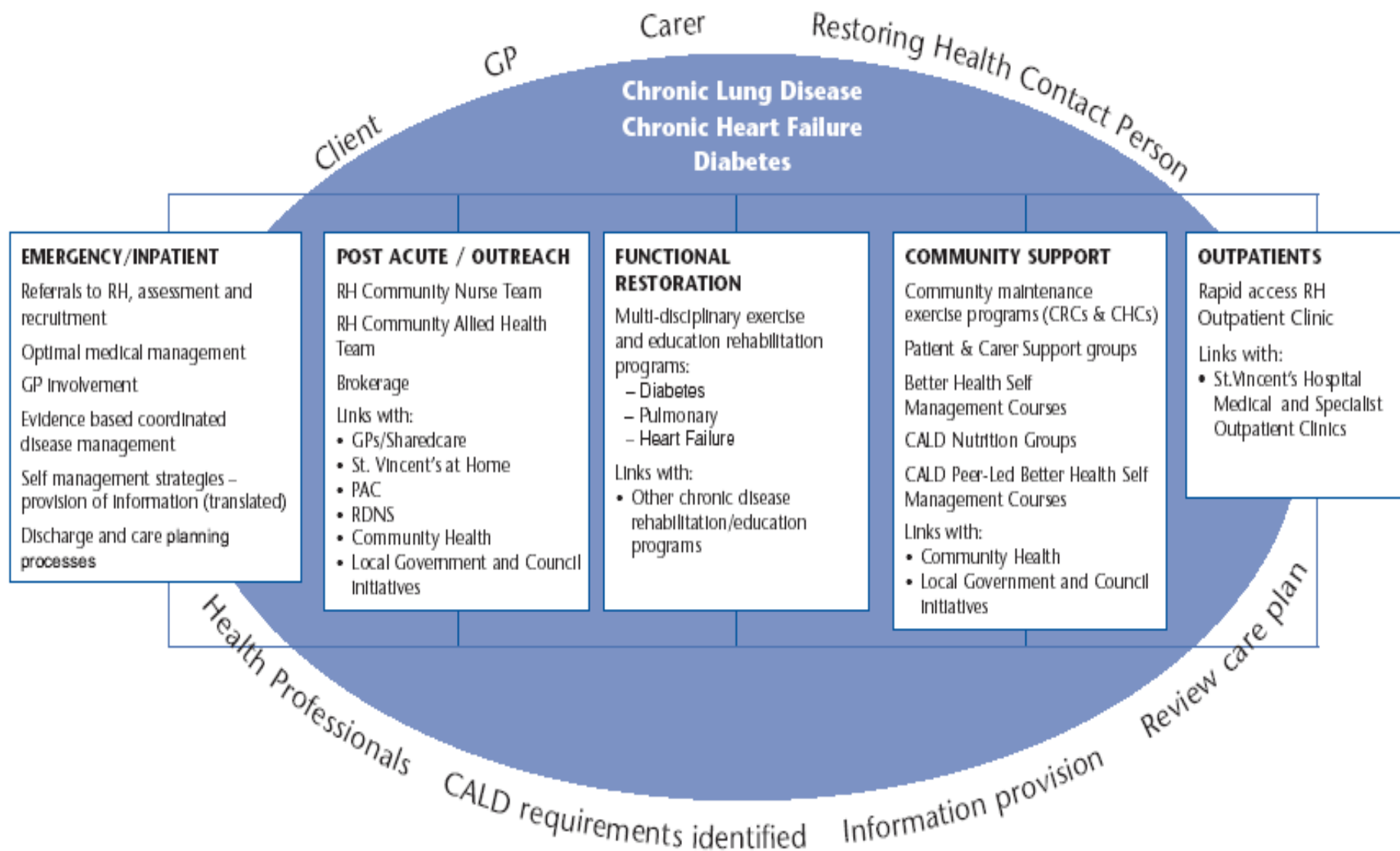
- Chronic Disease
- Moderate → severe severity
 - 71% lung disease (MRC Dyspnoea Gr 3-5)*
 - 67% heart failure (NYHA Gr III-IV)*
 - 56% diabetes (HbA1c > 8.1%)*
- Elderly: 61% > 70 yrs
- Live alone: 40%
- No carer: 65%
- CALD: 65% born overseas

Disease Diagnosis of Restoring Health Patients



one chronic disease = 13%
two or more chronic diseases = 87%

St.Vincent's Health – Restoring Health Model



Key contact persons

“The Glue”



- Central liaison point for client, carer, GP & community team
- Know each patient's baseline status
- Liaise at outpatient medical appointments
- Seamless navigation of health sectors
- Patient advocate
- Identify disease specific gaps
- Facilitates immediate follow-up care in community



ED & Inpatient phase

- Referrals: ED screeners (“ALERT”) & recruitment pagers.
- Where: SVH ED, Inpatients, Outpatient Clinics
- Who: T1 or T2, particularly unstable, poorly controlled DM.
 - More complex needs than usual care ie GP or SVH Diabetes Education service
 - Exclusion criteria: min symptoms, significant co-morbidities, no consent,

Mean HbA1C at recruitment = 9.1

~96% have diabetes-related complications

At time of recruitment

- **Assessment:** Diabetes CNC
 - Risk factors, complications & diabetes self-management strategies
 - Previous intervention/education
- **Intervention:**
 - Diabetes education (+/- family/care givers) +/- interpreters
 - Facilitate NDSS subscription if required
 - Care planning in conjunction with GP
 - Referrals to outreach team: nursing and allied health
 - 80-90% require more than RN alone
- **Links with:**
 - Dept of Endocrinology, General Medicine, Vascular, Renal; SVH clinics, SVH Diabetes Educators, SVH Podiatry

If / when represent to SVH

- Early liaison & referrals with Medical/RN/AH staff
- Monitoring BSLs on ward & appropriate medication management
- Ensuring accuracy and appropriateness of medication and device management
- Re-education and care planning as required
- Ward staff education/support
- Facilitate early discharge with follow up supports

Outreach

- RNs / Allied health
 - Continuation of careplan
 - Monitoring BSLs / initiate alteration where required
 - Reinforcing education & self management strategies established
 - Further referrals as required
- Liaise closely with GP & RH team
- Links with existing community services
- Back up plan → Rapid Assessment Clinic

Rapid Assessment Clinic

- 6 appointments across 4 days
- Referral to contact person from GP, client, RH staff or carer
- Rapid physician review & GP liaison
 - *Typically unexpected hyperglycaemia, infections, multi-disease factorial problems,*
- Access to pathology, radiology, pharmacy, diagnostics
- Majority return home post medical intervention / ↑ supports
- Immediate follow up in community

Restoring Health Program

Outpatients

- Links to clinics and physicians
 - Reassess clients
 - Advocacy
 - Address current issues
 - Handover pertinent details to physicians
 - Feedback to outreach staff
- ***Jan-June 2006: 352 appointments attended***

Diabetes Rehab

- 10 week outpatient exercise and education
- Darebin CRC
- RN, Physio, AHA
- Key outcomes
 - 6MWT
 - Generic QOL
- Refer on to maintenance programs
- Education topics:
 - Exercise
 - Diabetes management complications, hypo/hypers, medications,
 - Nutrition/label reading
 - OT
 - Optometry
 - Podiatry
 - Psychological self mx.
 - Shopping trip



Restoring Health Program



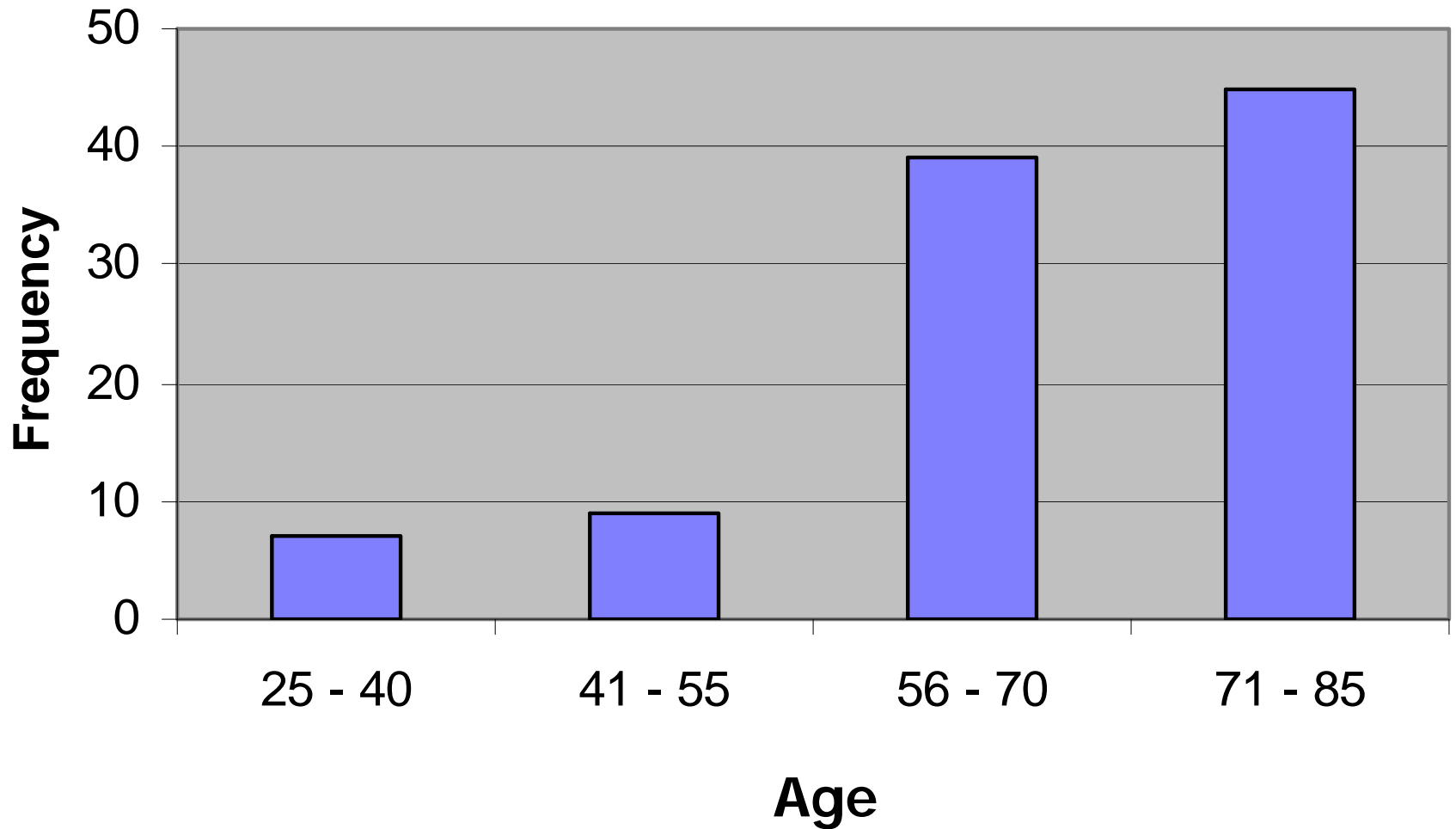
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Diabetes Rehab Outcomes...

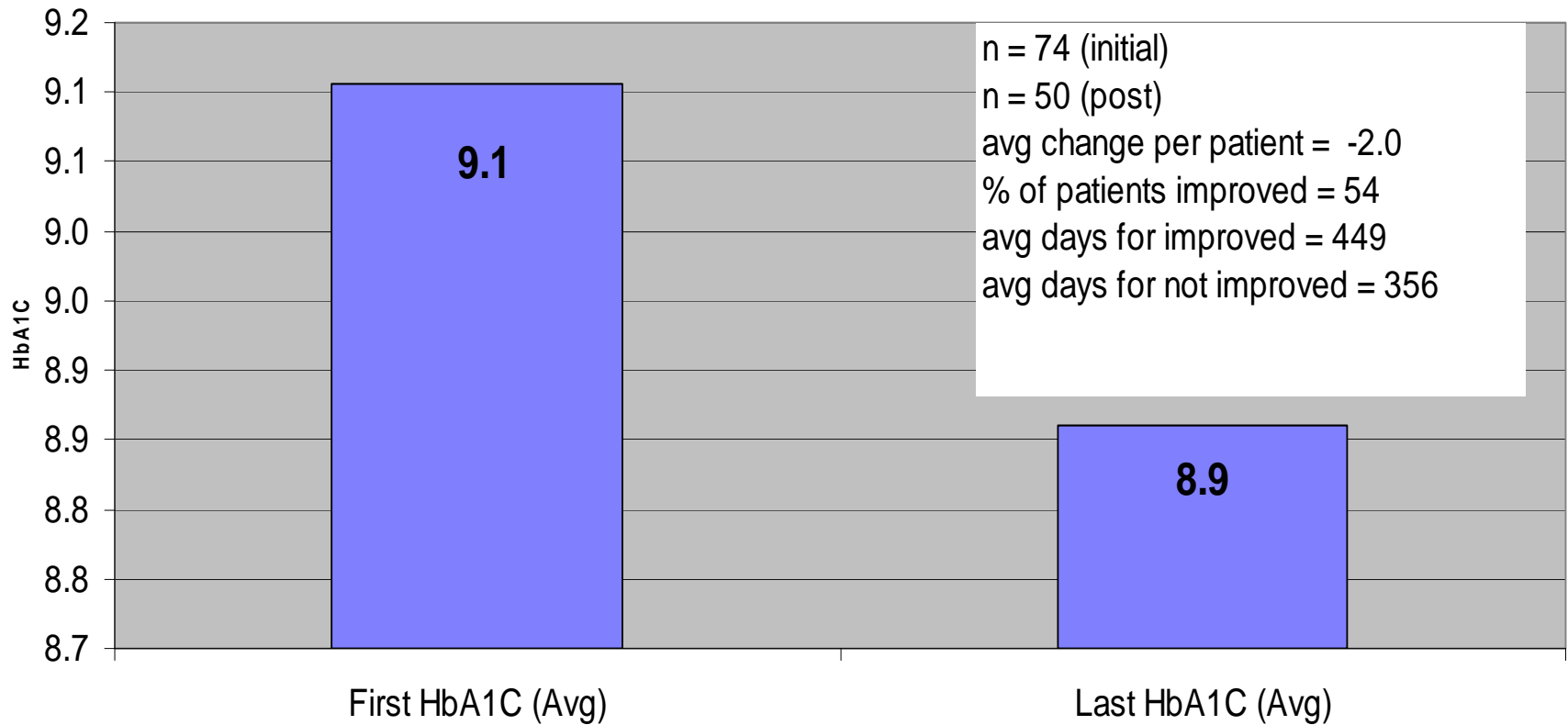


- QOL: SF-36 trial 2006
n=17
p<0.05 energy and well-being
- Function: 6 minute walk test
50% have clinically significant improvement
- HbA1C

Age of Restoring Health Diabetes Recruits Feb 03 - May 06



Restoring Health - HbA1C (Feb 2003 - May 2006)



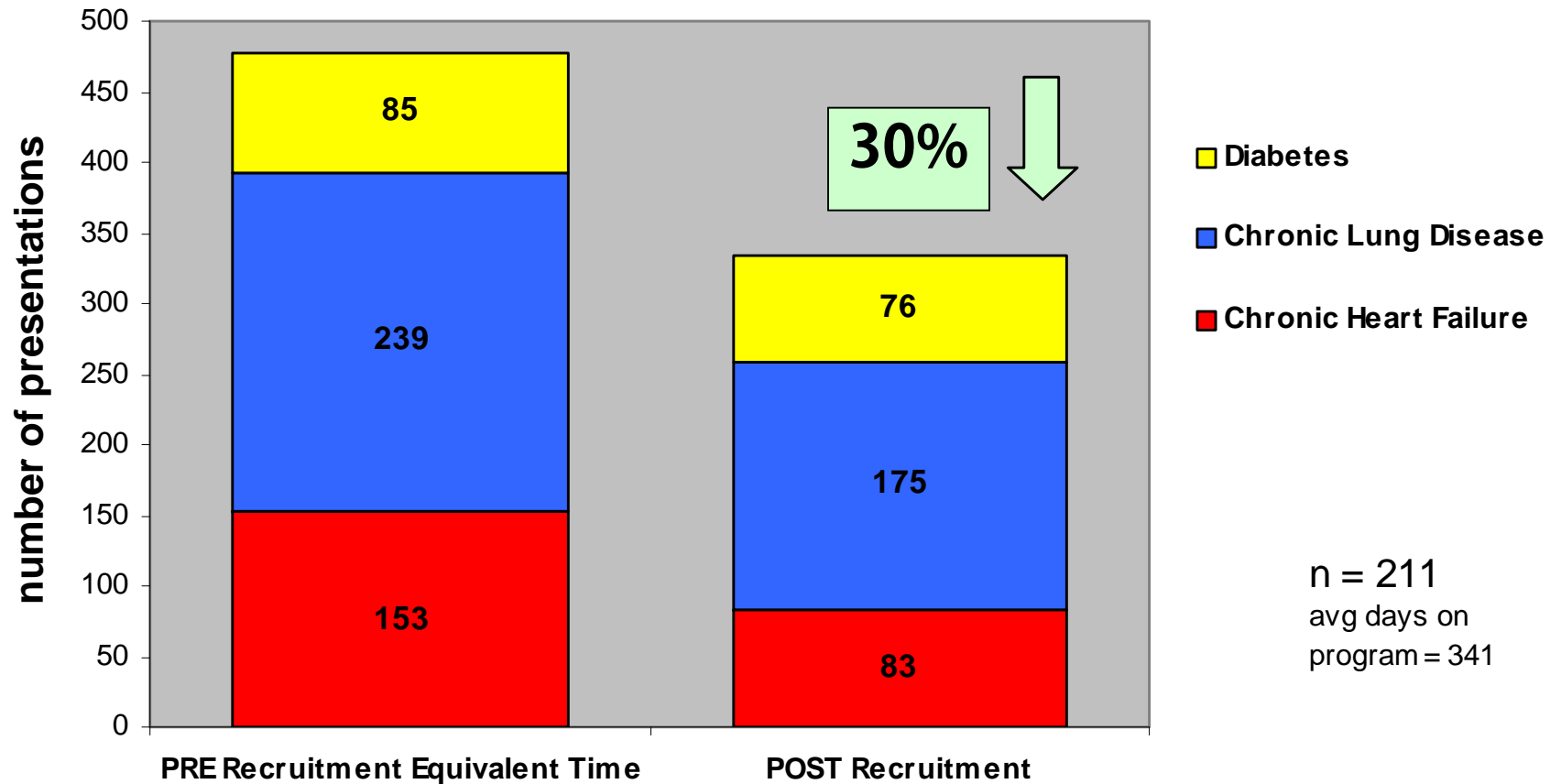
Healthcare Utilisation



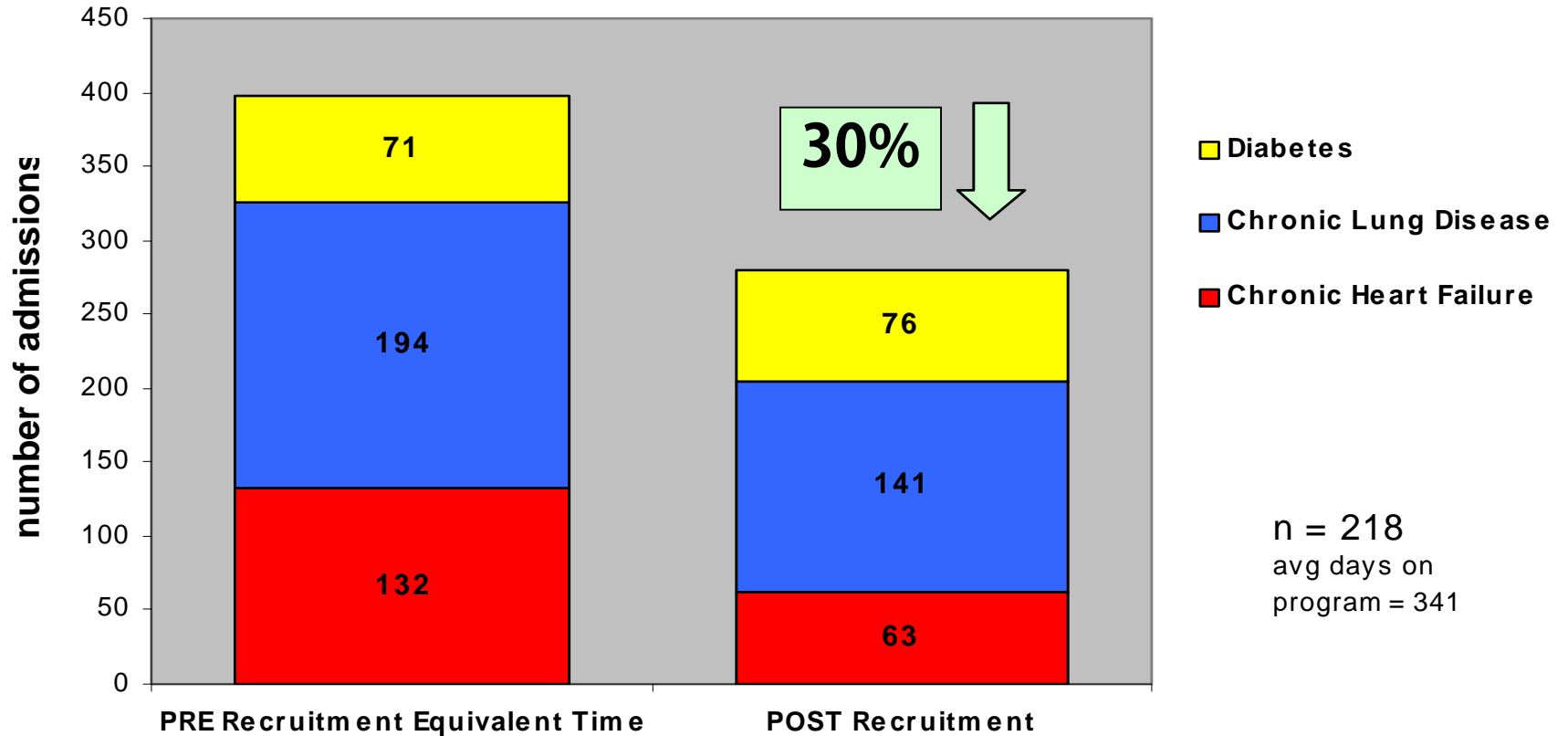
Restoring Health Program

Restoring Health Program (Feb 2003 - December 2005)

Total Number of Presentations

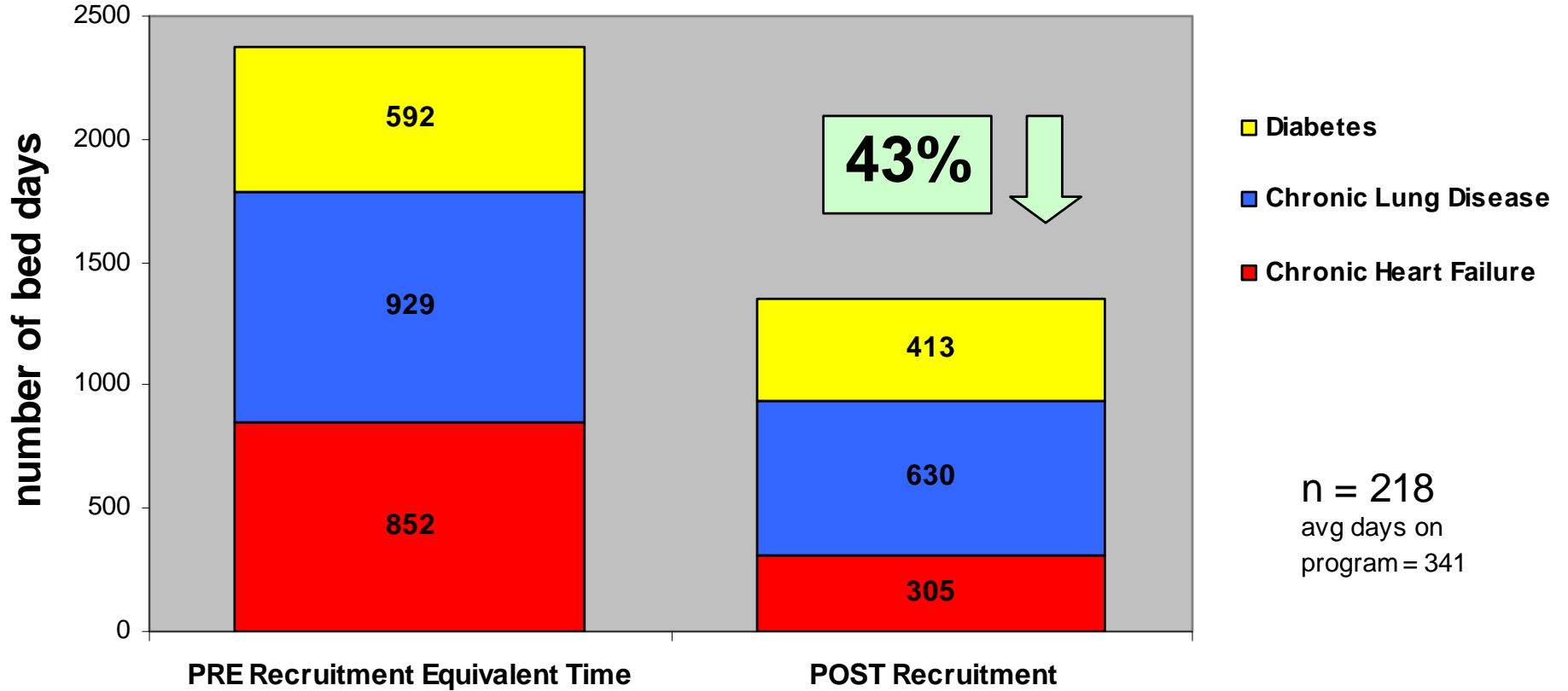


Restoring Health Program (Feb 2003 - December 2005)
Total Number of Admissions



Restoring Health Program (Feb 2003 - December 2005)

Total Bed Days



Key principles...

1. Restoring Health Key Contact Liaison Role
2. Integrated team across Acute and Community Sectors → common goals
3. Evidence-based disease specific care across the continuum
4. CLD, CHF and Diabetes *under the one umbrella*
5. Rapid Access Outpatient Clinic
6. Disease Specific Rehabilitation and Community Maintenance Programs
7. Integrated program for CALD backgrounds
8. Navigate, not replicate or duplicate