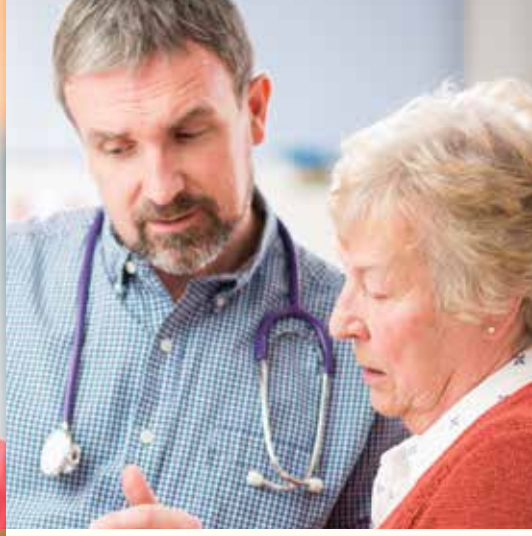








Western Queensland Diabetes Service Framework

Western Queensland Primary Health Network

OUR PEOPLE
OUR PARTNERSHIPS
OUR HEALTH

phn
WESTERN QUEENSLAND
An Australian Government Initiative

CONTENTS

INTRODUCTION

Western Queensland PHN consider diabetes as one of the top priorities for the region with this condition contributing to a significant burden of illness and with complications one of the main reasons for hospitalisation. In some of our remote communities the prevalence of diabetes impacts on up to 20 per cent of the population with many people also living with a mental illness and comorbidities. We also know that there is another large cohort of people that are undiagnosed with very little or no symptoms of a disease process. This makes screening for diabetes as a preventative measure an important consideration across the continuum of care.

This Diabetes Service Framework sets out a vision for our general practice networks including Aboriginal and Islander Community Controlled Health Services (AICCHSs) to optimise care for people living with a diagnosis of high-risk factors of diabetes. It outlines coordinated, ongoing and comprehensive primary healthcare for people with type 2 diabetes.

It will assist General Practices and primary care partners to implement contemporary approaches to address type 2 diabetes risk factors, providing early diagnosis and enhancing health outcomes for people living with type 2 diabetes.

The vision for optimal diabetes care in Western Queensland General Practices and AICCHSs is set out in the framework as:

- Healthy people are supported to maintain their health status.
- People at risk are supported to prevent or delay the development of type 2 diabetes.
- People with diabetes are supported to self-manage their condition and prevent or delay diabetes related complications.
- People with diabetes complications, comorbidities and complex health needs receive the right care, at the right place, at the right time, by the right team.
- General Practice has the enabling foundations in place to facilitate improvements in health outcomes for people with diabetes.

The Western Queensland Heath Care Home (WQ HCH) model of care presents the strategic direction for development of primary care services in the region and strengthens the role of general practice at the core of our health system. A WQ HCH aims to harmonise patient centred approaches and transform the way health care is delivered for a more seamless treatment approach providing better patient outcomes. The model will be the primary enabler to comprehensive primary health care both in the practice and in the surrounding neighbourhood of services.

Western Queensland PHN would like to thank Diabetes Queensland and its own Clinical and Consumer Advisory Council for assisting in the development of the Diabetes Service Framework. We sincerely support the uptake of the framework in the continuing journey to improve health outcomes for the people living in Western Queensland.

Stuart Gordon, *Chief Executive Officer, Western Queensland PHN*

I am pleased to introduce the first Diabetes Service Framework for the Western Queensland Primary Health Network. It marks an important step forward for people living with or at risk of type 2 diabetes in the region. This framework provides a practical guide for those in the General Practice setting concerned with prevention, detection and management.

People living in our remote communities are 1.8 times more likely to be hospitalised for diabetes and 1.9 times more likely to die from diabetes related complications. Aboriginal and Torres Strait Island people are nearly 4 times as likely to develop type 2 diabetes. With the lowest average life expectancy in the state, we cannot continue to accept the high price that is being paid daily by Queenslanders living in the Western Queensland Primary Health Network catchment area. We must challenge and address the issues inherent in remote health care provision.

I fully endorse this inaugural framework and recommend it to all health professionals working steadfastly to improve the health outcomes of Western Queenslanders.

Sturt Eastwood, *Chief Executive Officer, Diabetes Queensland*

Consultation has included the Western Queensland PHN Clinical and Consumer Advisory Councils and Diabetes Queensland.

1. SCOPE OF THIS FRAMEWORK

Living and working in regional and remote areas of Australia has been described as a risk to one's health. This is the case for diabetes. Hospitalisation and rates of death related to diabetes are twice as high in remote and very remote communities than in major Australian cities. People in Western Queensland rely on their General Practice to help them stay well and to manage their health conditions.

Through a GP-led or remote nurse-led multi-disciplinary team-based model of care, (hereafter referred to as GP-led), General Practice in whichever form it takes such as HHS managed clinic, privately owned, nurse-led with RFDS/Locum Doctor, FIFO/DIDO or AICCHS (hereafter called General Practice) offers continuity of primary health care and a gateway to the wider health system. General Practice gives people access to an integrated system of care with a continuing relationship to doctors and practice staff and connections to a multi-disciplinary team that includes clinical and social services within the community.

General Practice can support people living with diabetes to change from only seeking help when they are acutely unwell, to assisting them participate in planned, coordinated and structured care that better meets their needs.

This Diabetes Service Framework sets out a vision for general practice optimal care for people living with diabetes. It outlines coordinated, ongoing and comprehensive primary healthcare for people with type 2 diabetes.

To help reduce the growing number of people with this condition, it also includes practice population approaches to prevent people developing type 2 diabetes.

People AT RISK of type 2 diabetes
General practice can assist them in:

- preventing the condition, through modifiable risk factors
- early detection where the condition is already present

People LIVING WITH type 2 diabetes
General practice can assist by:

- supporting proactive management of their condition, increasing their knowledge, skills and confidence
- ensuring access to services such as the NDSS
- supporting them to live well, and reduce risk of complications
- managing co-morbidity, such as cardiac disease, mental health issues
- providing access to specialist care where the condition is advanced, and needs are complex.

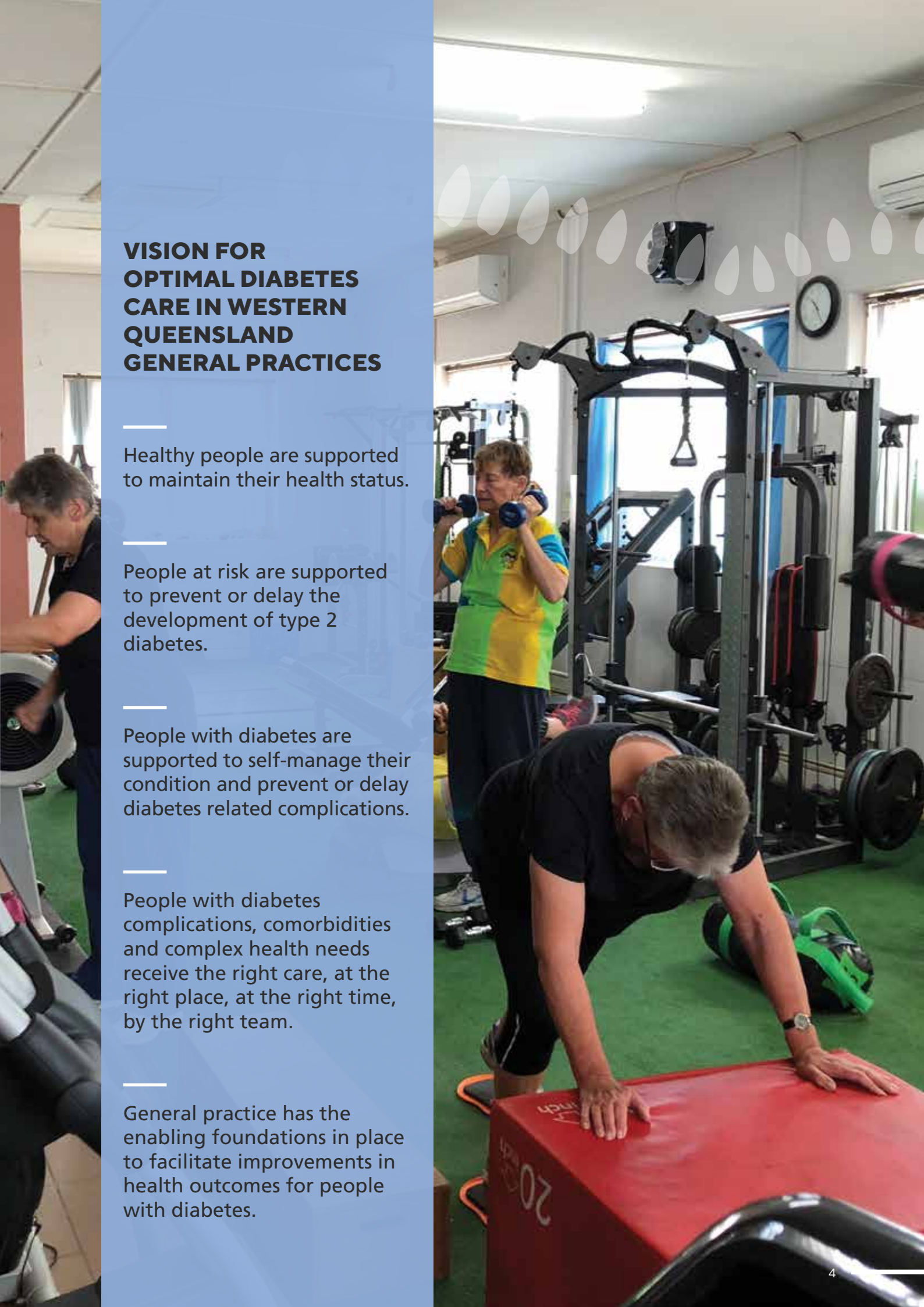
The Western Queensland Health Care Home Model of Care
will support practices to provide the right care in the right place, at the right time by the right team. At the heart of the model is a whole-of-system, patient-centred integration approach that is focused on improving the capacity and capability of general practice.

2. PURPOSE OF THIS DIABETES SERVICE FRAMEWORK AND VISION FOR DIABETES CARE

This service framework assists General Practice support staff in:

- **addressing type 2 diabetes risk factors, providing early diagnosis for those not yet identified as having the condition and preventing increased incidence**
- **enhancing health outcomes for people living with type 2 diabetes.**

It sets out the general practice approach to structured care for diabetes, considering the following three domains:



VISION FOR OPTIMAL DIABETES CARE IN WESTERN QUEENSLAND GENERAL PRACTICES

Healthy people are supported to maintain their health status.

People at risk are supported to prevent or delay the development of type 2 diabetes.

People with diabetes are supported to self-manage their condition and prevent or delay diabetes related complications.

People with diabetes complications, comorbidities and complex health needs receive the right care, at the right place, at the right time, by the right team.

General practice has the enabling foundations in place to facilitate improvements in health outcomes for people with diabetes.

3. WESTERN QUEENSLAND HEALTH CARE HOME (WQ HCH) MODEL OF CARE

The WQ HCH Model of Care presents the strategic direction for development of primary care services in the region and strengthens the role of General Practice at the core of our health system. A Health Care Home aims to harmonise patient-centred approaches and transform the way health care is delivered for a more seamless treatment approach providing better patient outcomes.

The Health Care Home Model of Care will be the primary enabler to comprehensive primary health care.

- Moving away from episodic and reactive approaches to support health maintenance.
- Placing greater emphases on services that support people to maintain their health.
- Motivating people living with diabetes to increase their knowledge, skills and confidence to self-manage their health.

WQ HCH provides proactive patient centred, coordinated, and flexible care with a team of health professionals working together to ensure the patient receives care based on their needs.

People at risk of, or living with diabetes who are enrolled in a Health Care Home will be able to experience:

READY ACCESS TO CARE

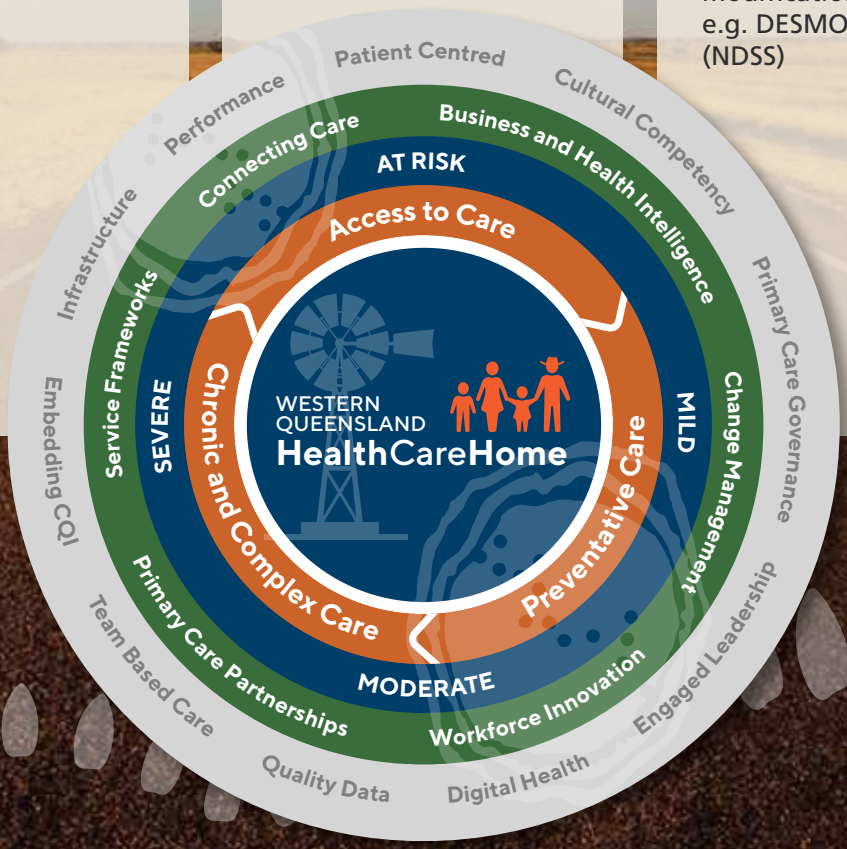
- Timely access to general practice such as online appointments
- Culturally appropriate support and treatment
- A range of communication methods that address health literacy status
- Nominated clinical and other health providers

PROACTIVE PREVENTATIVE CARE

- Identification of patients at high risk of developing type 2 diabetes
  - Use of data extraction tools, e.g. Cat4Plus
  - Regular use of AUSDRISK screening
- Promoting awareness of diabetes modifiable risks
- Regular use of health assessment, e.g. MBS item numbers: 40-49 type 2 Risk, 45-49, >75, Indigenous
- Referring at-risk patients to behaviour change/ lifestyle modification programs e.g. My health for life

ENGAGED COMPLEX AND CHRONIC CARE

- General Practice Management Plans (GPMP) providing patient focussed goals and clear clinical targets
- Practice Nurse/Aboriginal Health Practitioner (AHP) support in GPMP and patient education
- Completion of diabetes annual cycle of care, and best practice complication screening
- Referral under Team Care Arrangements to multidisciplinary team as required
- Referral to education, behaviour change/lifestyle modification programs e.g. DESMOND, SMARTS (NDSS)



Domains · Populations · Support for uptake · Foundations

4. WESTERN QUEENSLAND – CHRONIC CONDITIONS SNAPSHOT

POORER HEALTH OUTCOMES

WESTERN QUEENSLANDERS HAVE

Lower life expectancy compared with the rest of Queensland

The highest rate of potentially preventable hospitalisations of all PHN regions, with significantly higher rates compared with other Queensland regions

High number of hospital Emergency Department (ED) presentations for GP appropriate issues and for return planned visits to ED

17%

OF WESTERN QUEENSLANDERS IDENTIFY AS ABORIGINAL AND/OR TORRES STRAIT ISLANDER, WHICH IS HIGHER THAN THE STATE AVERAGE OF 3%.

COMPARED WITH NON-INDIGENOUS AUSTRALIANS, **INDIGENOUS AUSTRALIANS ARE**

NEARLY 4 X
as likely to have diabetes

4 X
as likely to be hospitalised for diabetes

4 X
as likely to die from diabetes

3 X
as likely to have insulin-treated type 2 diabetes

Diabetes accounts for 16%
of the life expectancy gap between Aboriginal and Torres Strait Islander and other Australians

INCIDENCE OF MODIFIABLE RISK FACTORS

WESTERN QUEENSLANDERS HAVE

Higher rates of **insufficient physical activity** in adults compared with the rest of Queensland

Higher rates of **adult daily smokers** compared with the rest of Queensland

Higher rates of **risky lifetime of alcohol consumption** compared with the rest of Queensland

Higher rates of **overweight and obesity** in men and women compared with the rest of Queensland

PREVENTABLE HOSPITALISATIONS

WESTERN QUEENSLANDERS WITH DIABETES COMPLICATIONS ACCOUNT FOR

25% of potentially preventable hospitalisations

AND OF THESE →

36% are admitted to hospitals outside the region

REMOTENESS: COMPARED TO THOSE LIVING IN MAJOR CITIES, **PEOPLE LIVING IN REMOTE AREAS ARE**

1.8 X as likely to be hospitalised for diabetes

1.9 X as likely to die from diabetes

SOCIOECONOMIC STATUS: COMPARED WITH THOSE LIVING IN THE HIGHEST SOCIOECONOMIC AREAS OF AUSTRALIA, **PEOPLE LIVING IN THE LOWEST SOCIOECONOMIC AREAS ARE**

3.6 X as likely to have diabetes

1.8 X as likely to be hospitalised for diabetes

2.0 X as likely to die from diabetes

5. DIABETES FACTS

DIABETES IS A
SERIOUS LIFE-LONG CONDITION

- It is a complex and progressive condition that affects all parts of a person's body

MODIFIABLE LIFESTYLE CHANGES SUCH AS:

- weight and waist measurements
- healthy eating
- physical activity
- smoking status

can prevent or delay the onset of type 2 diabetes and prevent or delay the onset of diabetes related complications.

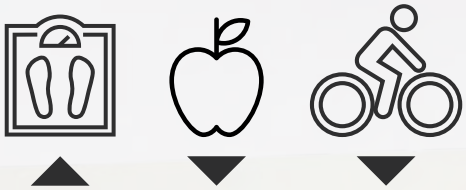
A PREVIOUS DIAGNOSIS OF GESTATIONAL DIABETES CARRIES A LIFETIME RISK OF PROGRESSION TO TYPE 2 DIABETES OF UP TO 60%.

Women with GDM require focused support during pregnancy and follow-up, so they are empowered to reduce their risk factors to prevent or delay the development of type 2 diabetes.

DIABETES IS MARKED BY
HIGH LEVELS OF GLUCOSE IN THE BLOOD, CAUSED EITHER BY THE INABILITY OF THE BODY TO PRODUCE INSULIN, OR BY THE BODY NOT BEING ABLE TO USE INSULIN EFFECTIVELY.

MODIFIABLE LIFESTYLE RISK FACTORS FOR TYPE 2 DIABETES ARE INCREASING IN AUSTRALIA

- High rates of overweight and obesity
- Declining vegetable & fruit consumption
- High levels of sedentary behaviour

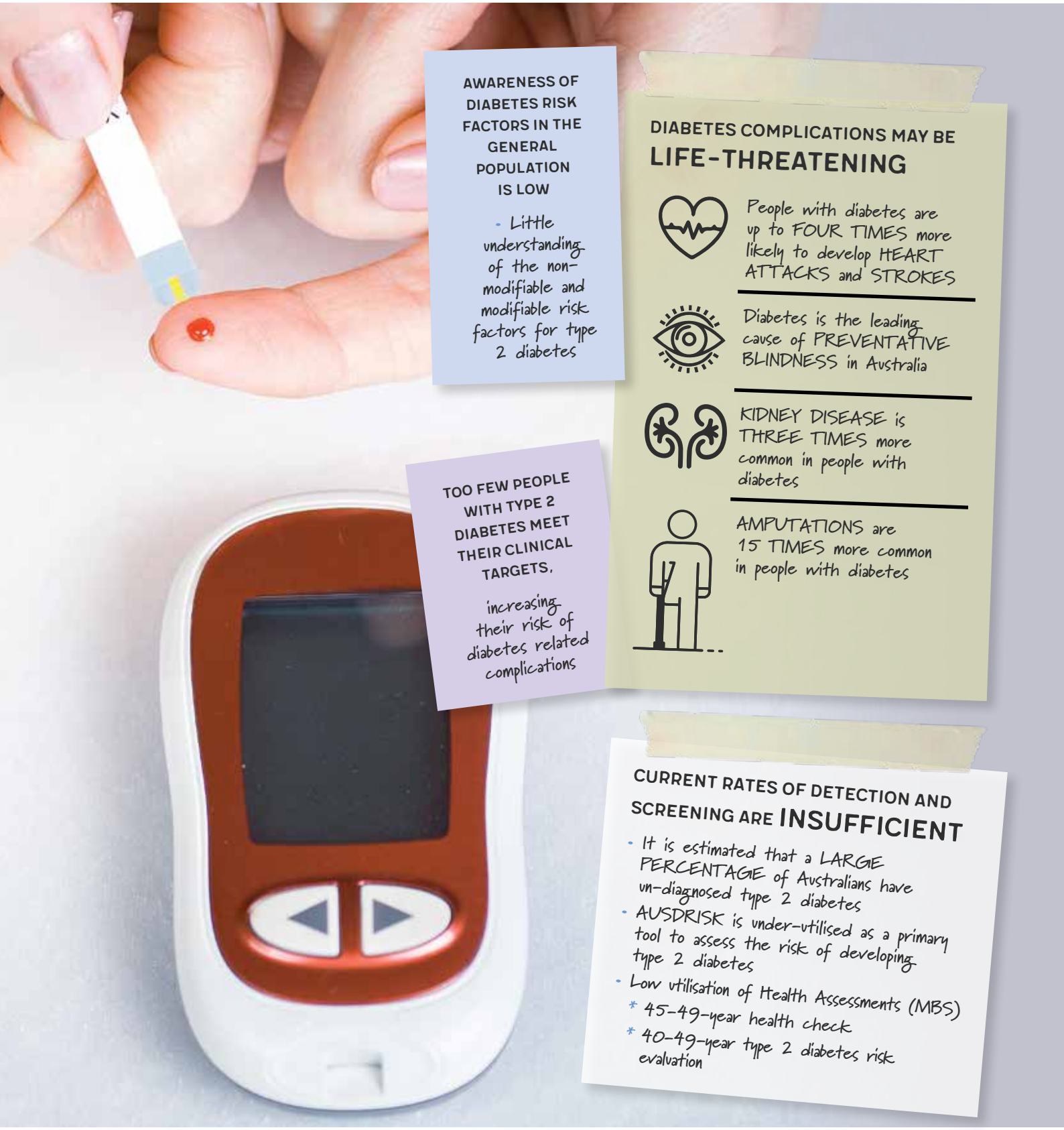


EARLY INTERVENTION AND PREVENTION STRATEGIES MAY SLOW OR HALT DISEASE PROGRESSION OF TYPE 2 DIABETES BY LIFESTYLE CHANGES ALONE

HIGHER RATES OF OVERWEIGHT AND OBESITY IN CHILDREN AND YOUNG PEOPLE IS RELATED TO THE INCREASING INCIDENCE OF TYPE 2 DIABETES IN YOUNGER AGE GROUPS.

DIABETES LINKS WITH MENTAL HEALTH

- Up to 50 PER CENT of people with diabetes also have a MENTAL ILLNESS such as depression or anxiety
- People with depression and diabetes may find it difficult to maintain daily self-management care



AWARENESS OF DIABETES RISK FACTORS IN THE GENERAL POPULATION IS LOW

- Little understanding of the non-modifiable and modifiable risk factors for type 2 diabetes

TOO FEW PEOPLE WITH TYPE 2 DIABETES MEET THEIR CLINICAL TARGETS.

increasing their risk of diabetes related complications

DIABETES COMPLICATIONS MAY BE LIFE-THREATENING

People with diabetes are up to FOUR TIMES more likely to develop HEART ATTACKS and STROKES

Diabetes is the leading cause of PREVENTATIVE BLINDNESS in Australia

KIDNEY DISEASE is THREE TIMES more common in people with diabetes

AMPUTATIONS are 15 TIMES more common in people with diabetes

CURRENT RATES OF DETECTION AND SCREENING ARE INSUFFICIENT

- It is estimated that a LARGE PERCENTAGE of Australians have un-diagnosed type 2 diabetes
- AUSDRISK is under-utilised as a primary tool to assess the risk of developing type 2 diabetes
- Low utilisation of Health Assessments (MBS)
  - 45-49-year health check
  - 40-49-year type 2 diabetes risk evaluation

6. DIABETES CONTINUUM AND RISK LEVELS

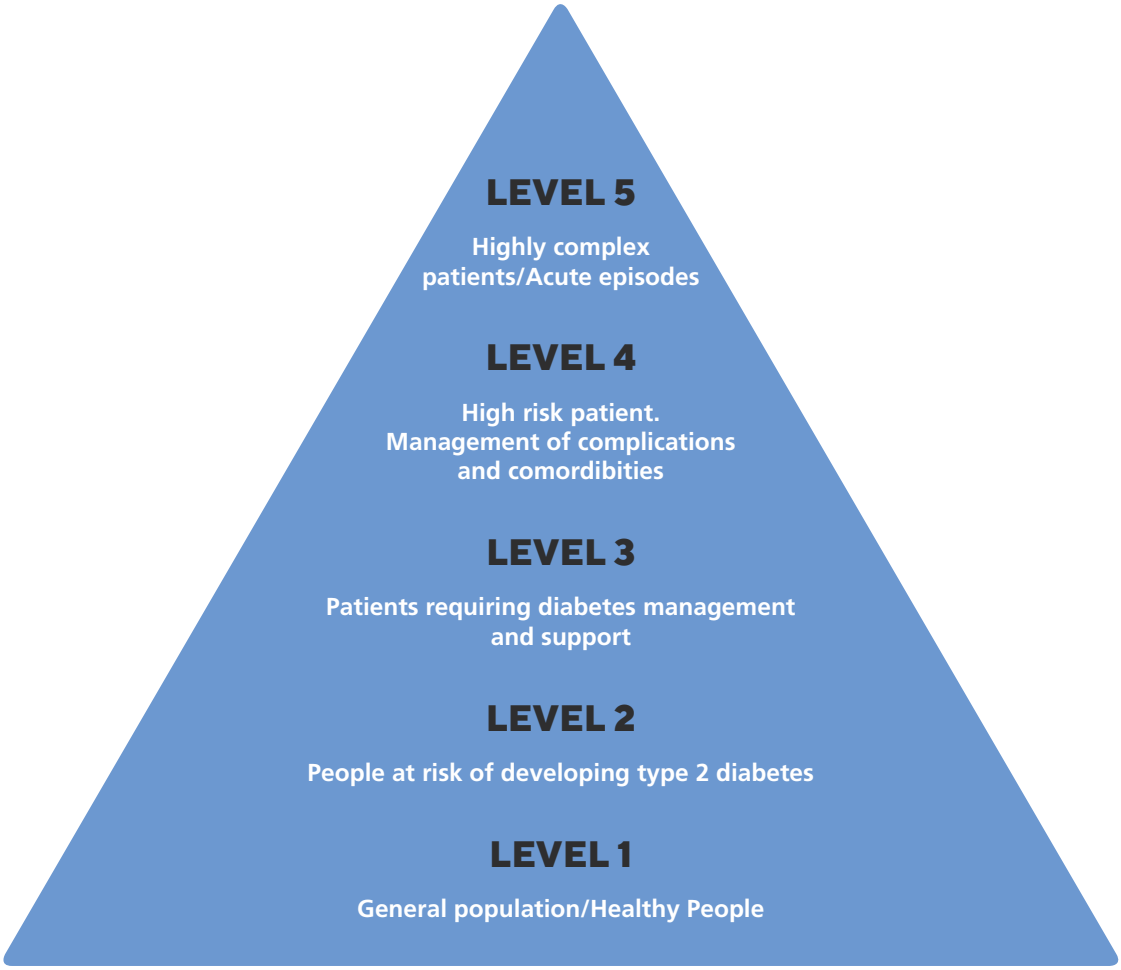
Chronic condition prevention, management and acute care is a continuum. It commences with the identification of risk factors and diagnoses, then progresses to condition management and can escalate to acute care requiring complex case management.

Each risk level along this continuum requires a different primary health care response.

General Practice has traditionally focussed its attention when patients living with type 2 diabetes present with complications. From a risk perspective as depicted in the 5-part pyramid below, such a patient is considered at Level 4 having an advanced condition.

Using a structured, prevention and chronic disease management approach, General Practice can aim to enhance the care of patients at an earlier stage in the condition continuum, particularly for those who require diabetes management support (level 3), and the support to people at high risk of developing diabetes (level 2).

This approach requires the whole practice team of Practice Nurses, Aboriginal and Torres Strait Islander Health Practitioner/Workers, Reception/Administration, Doctors and Practice Managers to act across the care continuum to meet the needs of patients at all levels of the risk spectrum.

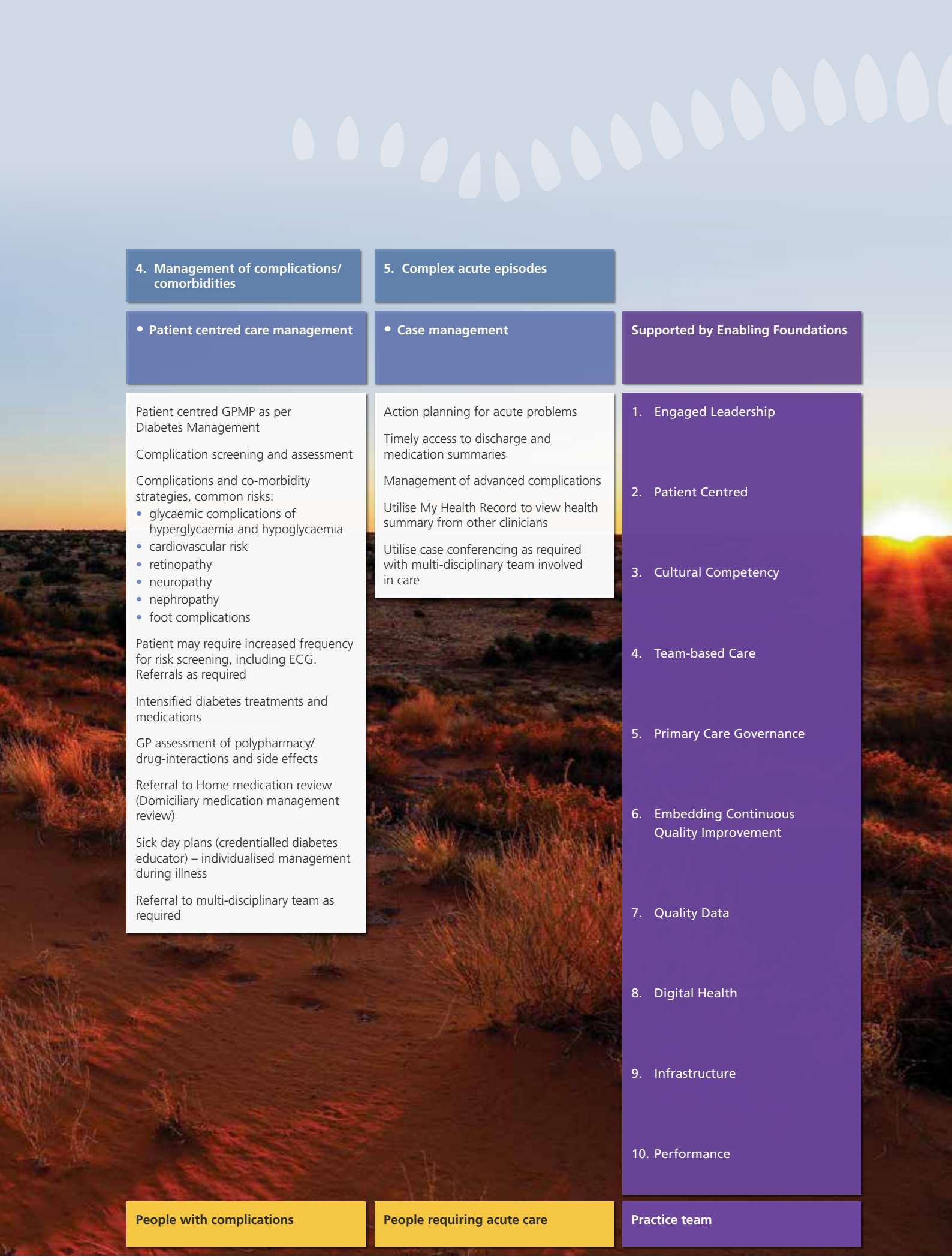


(Adapted from Improvement Foundation, 2013. Collaborative handbook: Diabetes prevention and management.)

WESTERN QUEENSLAND CONTINUUM OF DIABETES CARE

GP LED COORDINATED MULTI-DISCIPLINARY PREVENTION, DETECTION AND MANAGEMENT

1. General population	2. At risk of diabetes (pre-diabetes)	3. Diabetes management
• **Maintain healthy lifestyle**	• **Awareness, screening, detection** • **Reduce modifiable risk factors**	• **Patient centred GPMP** • **Lifestyle modification** • **Annual diabetes cycle of care**
Maintain healthy diet, weight and exercise Awareness of non-modifiable diabetes risk factors	Increase awareness of type 2 diabetes risk Risk assessment screening using AUSDRISK (every 3 years from 40 years) CVD complication screening using Absolute cardiovascular risk calculator 40-49 years Type 2 Diabetes Risk Evaluation (MBS Health Assessment following high risk AUSDRISK (score) Health Assessments (MBS): • 45 to 49 years • 75 years • Aboriginal and Torres Strait Islander Screen individuals at high risk with pathology such as fasting glucose Screen women with previous GDM who are at increased risk of type 2 diabetes Referral to community-based lifestyle modification programs to reduce modifiable risk: diet, weight, physical activity, smoking: Such as: • My health for life (phone or group) • Quitline • Get Healthy	Register with the NDSS on diagnosis of diabetes Initial assessment and education to explain condition, and encourage self-management GPMP with patient focussed goal setting. Utilise Practice Nurse/AHP in GPMP development and review, reinforcing education and goals Clear targets: blood glucose, blood pressure, lipids, diet, weight, exercise Commence ongoing screening and diabetes annual cycle of care, with regular reviews: • blood glucose/HbA1c • blood pressure • foot assessment • comprehensive eye exam • microalbumin level/eGFR • lipids • weight/BMI (and waist) • Healthy eating, physical activity, medication, emotional health, smoking Referral to structured self-management support groups (NDSS and Diabetes Queensland) Referral to behaviour change, lifestyle modification programs Commencement of medication as required Referral to multi-disciplinary team as required: • Diabetes educator • Dietitian • Podiatrist • Aboriginal health worker • Endocrinologist • Optometrist/Ophthalmology • Dentist • Exercise physiologist • Psychologist/Mental Health • Pharmacist • Social Worker Monitoring of reproductive health issues
Healthy people	**High risk people**	**People with diabetes**



4. Management of complications/ comorbidities	5. Complex acute episodes	
• Patient centred care management	• Case management	Supported by Enabling Foundations
Patient centred GPMP as per Diabetes Management Complication screening and assessment Complications and co-morbidity strategies, common risks: • glycaemic complications of hyperglycaemia and hypoglycaemia • cardiovascular risk • retinopathy • neuropathy • nephropathy • foot complications Patient may require increased frequency for risk screening, including ECG. Referrals as required Intensified diabetes treatments and medications GP assessment of polypharmacy/ drug-interactions and side effects Referral to Home medication review (Domiciliary medication management review) Sick day plans (credentialled diabetes educator) – individualised management during illness Referral to multi-disciplinary team as required	Action planning for acute problems Timely access to discharge and medication summaries Management of advanced complications Utilise My Health Record to view health summary from other clinicians Utilise case conferencing as required with multi-disciplinary team involved in care	1. Engaged Leadership 2. Patient Centred 3. Cultural Competency 4. Team-based Care 5. Primary Care Governance 6. Embedding Continuous Quality Improvement 7. Quality Data 8. Digital Health 9. Infrastructure 10. Performance
People with complications	**People requiring acute care**	**Practice team**

7. PRIMARY CARE RESPONSE BY RISK LEVEL

PATIENTS ARE SUPPORTED TO MAINTAIN THEIR HEALTH

ACTIONS BY GENERAL PRACTICE

- healthy people have an awareness of maintaining health enhancing behaviours
- awareness of healthy eating guidelines
- awareness of physical activity and sedentary behaviour guidelines
- awareness of healthy BMI range
- awareness of non-modifiable diabetes risk factors as may be relevant (age/ethnicity/GDM)
- maintaining cholesterol and blood pressure levels in target
- encourage awareness of healthy food choices in community e.g. schools
- encourage smoking cessation – refer to Quitline.

FAST FACTS

Smoking as a risk factor.

SMOKING INCREASES THE RISK OF DEVELOPING DIABETES BY **30-40%**.

HEALTHY LIFESTYLE CHOICES:

- Eat 5 serves of vegetables and 2 serves of fruit each day
- Drink plenty of water each day
- Spend less time sitting
- Quit smoking
- Consume less than 2 alcoholic drinks a day
- Sleep 6 – 8 hours each day

PEOPLE AT HIGH RISK OF DEVELOPING TYPE 2 DIABETES ARE SUPPORTED TO PREVENT OR DELAY DEVELOPING THE CONDITION

PLANNED AND STRUCTURED GENERAL PRACTICE STRATEGIES INCLUDE:

- systematic use of AUSDRISK as detection screening for those at risk of developing diabetes. Every 3 years from 40 years of age and more frequently for those individuals at higher risk. High risk individuals to be screened with fasting blood glucose pathology every 12 months:
  - women with history of GDM
  - previous cardiovascular event
  - women with polycystic ovary syndrome
  - patients on antipsychotic drugs
- systematic use of Health Assessments (MBS) to screen for chronic disease risk factors targeting:
  - Aboriginal and Torres Strait Islander people
  - 40-49 years Type 2 Diabetes Risk Evaluation
  - 45-49
  - >75 years
- refer patients to lifestyle modification programs:
  - **My health for life** behaviour change (www.myhealthforlife.com.au)
  - **Quitline** for smoking cessation (www.quitline.com.au)
- increase awareness of modifiable risk factors with access to healthy eating brochures and physical activity fact sheets
- overweight and obese patients
  - discuss strategies to reduce Obesity such as **Change Program** (GP led weight loss)
  - referral to **Get Healthy** – free personalised health coaching (Qld Health – www.gethealthyqld.com.au)
- pregnancy: planning for the best start
- employing brief intervention strategies or counselling techniques such as motivational interviewing to elicit behaviour change talk.

FAST FACTS

Losing 5-10% if current body weight can prevent type 2 diabetes in nearly **6 out of 10** people.

Early diagnosis of type 2 diabetes provides early access to effective interventions which may delay or prevent micro and macrovascular diabetes related complications affecting the eyes, kidneys and circulatory system.

AWARENESS OF SYMPTOMS

- feeling tired or weak
- go to the toilet a lot
- feeling thirsty
- leg cramps
- feeling itchy
- sores and boils that won't heal
- blurry vision
- pins and needles
- feeling grumpy or angry.

UNDERSTANDING NON-MODIFIABLE AND MODIFIABLE RISK FACTORS

NON-MODIFIABLE RISK FACTORS

- Age. Most people have increased risk after age 40.
- Genetics. Family history and ethnicity. Some ethnic groups carry a higher risk of developing diabetes such as Aboriginal and Torres Strait Islander peoples.
- History of gestational diabetes.

MODIFIABLE RISK FACTORS

- overweight/obesity
- physical inactivity
- high blood pressure (hypertension)
- high cholesterol (lipid) levels.

Employing brief intervention strategies or counselling techniques such as motivational interviewing to elicit behaviour change talk.

REFERRAL TO BEHAVIOUR CHANGE AND LIFESTYLE MODIFICATION PROGRAMS

MY HEALTH FOR LIFE

My health for life is a free evidence-based behaviour modification program specifically designed for people at high risk of developing chronic disease. Participants are guided to set goals and action healthy lifestyle changes.

Refer eligible patients to the program:

- 45 years and over with AUSDRISK ≥12 (18 plus for Aboriginal and Torres Strait Islander peoples) or people aged 18 years and over with pre-existing conditions (pre-diabetes, high BP, high cholesterol or previous GDM
- referral templates on practice software are available
- one to one telephone health coaching available in all locations
- several communities in Western Qld have access to local facilitated groups.

www.myhealthforlife.com.au

QUITLINE

Call Quitline for free information, practical assistance and support.

Quitline is a confidential telephone service, dedicated to helping people quit smoking. The service is available seven days a week for the cost of a local call (except mobiles). Trained counsellors provide support, encouragement and resources to help you through the process of quitting. Callers to the Quitline have access to translation services and printed quit materials in 13 different languages. Tailored information and assistance is also available for young people, pregnant women, people with a mental illness, and Aboriginal and Torres Strait Islander people.

13 QUIT (13 7848)

www.quithq.initiatives.qld.gov.au

GET HEALTHY

A free personalised health coaching service.

- 10 confidential coaching calls over six months – all at a time and day that suits you
- motivation and support to set your own healthy lifestyle goals
- information and a journal to help you track your goal and actions
- help to overcome any problem areas.

Your health coach could help participants to:

- eat healthily
- get active
- achieve and maintain a healthy weight.

www.gethealthyqld.com.au

PEOPLE WITH DIABETES ARE SUPPORTED TO SELF-MANAGE THEIR CONDITION AND REDUCE THE RISK OF DIABETES RELATED COMPLICATIONS

PLANNED AND STRUCTURED GENERAL PRACTICE STRATEGIES INCLUDE:

- registration with the NDSS upon diagnosis for access to support, education and information
- individual GPMP is commenced with regular reviews scheduled
- practice nurse/Aboriginal Health Practitioner has key role in GPMP development and education
- patients are supported to understand their individualised targets such as blood glucose levels, blood pressure and cholesterol levels
- newly diagnosed are referred to Diabetes Education (group and/or individual)
- ensure correct use of Chronic Disease Management (MBS) item numbers to assist with planned and structured care
- diabetes annual cycle of care components a re regularly and fully completed by general practice
- referral to multi-disciplinary care is coordinated using Team Care Arrangements (MBS)
- discuss access to psycho-social support and refer where required
- patients are referred to diabetes education and self-management programs as available
- patients are referred to lifestyle modification programs (if not local, phone-based programs)
- additional referrals as required such as to diabetes specialists, medication reviews
- patients are supported to understand the role of lifestyle modification; healthy food choices; physical activity and medication adherence.

FAST FACTS

AIMING FOR GLYCAEMIC TARGETS OF HBA1C AT ≤7 % reduces the risk of diabetes-related complications.

EDUCATION TO SUPPORT SELF-MANAGEMENT is essential and involves health professionals assisting people with diabetes so they can:

- understand their condition
- participate in their GPMP development and review
- understand lifestyle modifications
- be aware of the symptoms and signs of hyperglycaemia.

COACH PROGRAM®

The COACH Program® aims to improve quality of life and reduce avoidable hospital admissions through structured telephone-based self-management support. The program is delivered by Registered Nurses with additional training in self-management. Running for approximately 6 months with phone calls every 4-6 weeks, individuals are supported to better manage the symptoms related to their chronic disease. This is a free Queensland Health Program available for people with T2DM.

13 HEALTH (13 43 25 84)
Coach@health.qld.gov.au

CHANGE PROGRAM

The Change Program is a GP led weight management program for adults in Australian general practice. The program focuses on long-term, sustainable changes to nutrition and physical activity. With a GP handbook, patient workbook and clinical software templates, the Change Program has been developed to be used in a one-on-one setting with a person's GP.

www.changeprogram.com.au

PEOPLE WITH DIABETES RELATED COMPLICATIONS, COMORBIDITIES AND COMPLEX HEALTH NEEDS RECEIVE THE CARE THEY NEED

PLANNED AND STRUCTURED GENERAL PRACTICE STRATEGIES INCLUDE

- completing and reviewing a patient centred GPMP as per diabetes management
- setting treatment priorities with the patient that focus on what matters most to the individual in accordance with their values and preferences
- diabetes annual cycle of care components are regularly and fully completed
- ensuring complication screening and assessment is undertaken:
  - glycaemic targets to identify hyperglycaemia and hypoglycaemia
  - cardiovascular health
  - retinopathy prevention
  - neuropathy check
  - nephropathy pathology
  - foot check
  - medication review by GP
  - mental health review
- checking if patients require increased frequency of risk screening, and additional tests such as ECG or intensified diabetes treatments and medications
- referral to Home Medication Review to consider polypharmacy, drug-interactions and side effects.

FAST FACTS

- **REGULAR (TWICE YEARLY) FOOT CHECKS** can help prevent lower limb amputation

MANAGING SICK DAYS

Education about and preparation of a personalised sick day action plan and sick day management kit for use at times of illness.

PEOPLE WITH ACUTE CARE NEEDS RECEIVE THE FOLLOW UP TREATMENT THEY REQUIRE

PLANNED AND STRUCTURED GENERAL PRACTICE STRATEGIES INCLUDES FOLLOW UP OF

- action planning for acute problems including new referrals, changes to regimen and education requirements post discharge
- timely access to discharge and medication summaries and coordination of follow up appointment following discharge
- management of advanced complications (such as dialysis, amputation, neuropathy) with communication to appropriate specialist services
- use of My Health Record to access discharge summaries, medication summaries and shared health summaries.

8. ENABLING FOUNDATIONS

Achieving effective and high-quality planned and structured care for patients across the type 2 diabetes spectrum is a challenging task. It requires a coordinated and timely interaction between patients and healthcare providers throughout the continuum of diabetes management support. For General Practice to deliver their role providing comprehensive primary health care, it must be supported by enabling foundations. The following ten foundations align with the WQ HCH model of care.

1. ENGAGED LEADERSHIP

- Practice leaders provide transparent and sustainable leadership to lead cultural change, as well as specific strategies to improve quality.
- Leaders share with staff the vision of a continuum of diabetes care.
- Practice teams are supported to schedule protected time for GPMP work-ups and reviews, preventive health and quality improvement activities such as the model for improvement including Plan, Do Study, Act (PDSA) cycles.
- Practice values are embedded into staff recruitment, orientation and training.
- Leaders encourage teams to define diabetes focussed goals for their practice, (such as: increase number of GPMPs for people living with diabetes by 20% within 6 months).

2. PATIENT CENTRED

When patient centred principles are embedded into practice activities, patients can take a leading role in setting and meeting their own health care goals. The practice follows patient centred principles as defined by the Australian Commission on Safety and Quality in Health Care. Examples include:

- patients are involved in their care and have a point of contact in their practice care team
- care coordination is embedded into practice procedures and is evidenced when patients are helped to navigate the health system, using GPMP and TCA to access the care and services they need
- health promotion and patient education is aided by communication that supports heath literacy
- patients are referred early and appropriately
- patients are assisted with scheduling forward medical appointments
- patient care is integrated and the flow through the practice is seamless ensuring patients do not need to repeat their stories
- case conferencing is used as a vehicle to ensure external providers involved in the patient's care are included in patient care planning and decision making; being inclusive of the patient and carers
- encouraging patients to expand their role in decision making, health related behaviours and self-management.

GENERAL PRACTICE MANAGEMENT PLANS (GPMP)

GPMPs are the foundation of effective chronic disease management. They provide an approach where plans are developed collaboratively with the GP and the patient. Goal setting is patient focussed, not provider focussed and encourage patients take responsibility for their care by focusing care and treatment on specific relevant needs. Practice Nurse/AHP can play a critical role in GPMPs.

Targeting ongoing care, GPMPs can be used to:

- review the patient's overall sense of wellbeing, ability to cope and self-manage with diabetes
- review the SNAP lifestyle interventions being: Smoking persistence or relapse, Nutrition and diet, Alcohol intake and Physical activity
- review other comorbidities
- document management goals and actions for the patient
- describe treatment and services a patient will require in their arrangements
- consider holistic approach. If Mental Health Treatment Plan (MHTP) and/or Home Medicine Review (HMR), Case Conferencing is required.

MBS rebates are available for one GPMP per year, unless clinically required more frequently. Recommended review frequency is six-monthly, for ongoing care and follow-up, however the minimum period for review covered under MBS is 3-monthly.

GATEWAY TO MULTIDISCIPLINARY CARE – TEAM CARE ARRANGEMENTS (TCA)

GPs have a key role in linking and referring patients for diabetes education and treatment with allied health practitioners and specialists, such as diabetes educators and endocrinologists. MBS increases access to allied health via TCAs providing referral for rebated allied health services, for up to five allied health appointments per calendar year. Clear communication between the proivders is essential. A GPMP must be completed to access this extra service.

GROUP ALLIED HEALTH SERVICES FOR DIABETES

Specific to diabetes, MBS supports group services conducted by either a Credentialled Diabetes Educator, Accredited Practicing Dietitian or Exercise Physiologist. Patients must have a GPMP and be referred by a GP. Following an individual assessment with one of the above health professionals, patients can attend up to eight group sessions that support the self-management of diabetes focussing on lifestyle modifications such as physical activity and healthy food choices.

NURSE FOCUSSED CHRONIC DISEASE MANAGEMENT

Nurses and Aboriginal and Torres Strait Islander Health Practitioners (AHPs) can directly support patients with routine treatment and ongoing monitoring. MBS provides remuneration for the monitoring and support for a person with diabetes by a Practice Nurse or AHP. Monitoring activities include checks on clinical progress, such as waist measurement, self-management advice, such as lifestyle management advice or referral, and collection of information to support GPMP reviews.

The patient must have a current GPMP and may access several services in a calendar year. The GP is not required to be present while the care or monitoring is undertaken, as the Nurse/AHP continues to be under the GP's supervision.

3. CULTURAL COMPETENCY

Cultural awareness programs and tools can help build improved competency and safety in primary health care services for Aboriginal and Torres Strait Islander peoples and people from linguistically diverse backgrounds.

Examples of cultural competency include:

- cultural awareness training is embedded within practice team policy
- culturally diverse patients are identified within the practice clinical information system
- staff communicate with patients in a culturally appropriate manner and at a level the patient understands, increasing the patients' health literacy
- practice staff draw on the cultural knowledge of the local Aboriginal and Islander Community
- health professionals use techniques for low health literacy, such as 'teach back' (getting the patient to 'teach back' what has been discussed) to ensure patients understand the information they have received.

The National Diabetes Services Scheme (NDSS) provides resources in several languages via the Multicultural Diabetes Portal (www.multiculturalportal.ndss.com.au) and has targeted resources for Aboriginal and Torres Strait Islander peoples such as the Feltman tool video (www.diabetesqld.org.au).

4. TEAM-BASED CARE

Team-based care is evidenced where staff have defined roles, tasks are distributed within a team-based approach and all team members are supported to work at the top of their scope of practice. The team approach helps to build proficiency of team members. Examples include:

- position descriptions clearly describing role responsibilities
- team members understanding their own and their colleagues' scope of practice and work responsibilities
- professional development opportunities are used to upskill diabetes knowledge, chronic condition management and multi-disciplinary team work
- policies and procedures assist in providing a consistent team approach and the use of structured recall and reminder systems e.g. Annual Cycle of Care, GPMP and/or TCA.

PRACTICE NURSES/AHPS HAVE AN IMPORTANT ROLE IN CHRONIC DISEASE MANAGEMENT

Practice nurses and Aboriginal Health Practitioners (AHP) supported to work at the top of their scope of practice. Examples include:

- key role in GPMP development; whether with clinical work-up, completion for GP review or reviewing GPMPs on behalf of the GP
- active role in behaviour/lifestyle coaching with patients with the use of motivational interviewing (counselling approach) and education activities
- overseeing the practice diabetes register
- leading and supporting other practice staff to maintain a structured recall and reminder system to recall patients to the practice to complete their annual cycle of care, review GPMP or TCA.

5. PRIMARY CARE GOVERNANCE

Effective governance in General Practice can be optimised using systematic processes so that patients receive the right care in the right place at the right time. Diabetes management strategies require an emphasis on planning, with general practices being proactive in the diabetes strategies they provide. Planned and structured support and treatment which encourage patients to participate in self-management are essential. Examples include:

- Chronic Disease Management with a patient centred focus and the use of Practice Incentives (MBS) as support, are maximised
- health assessments are completed to identify people at risk of type 2 diabetes
- health assessments, recalls and reminders are tracked, providing timely proactive patient care
- pathology data is gathered and entered into the review documents prior to a patient visit
- patient data is used to identify diabetes cohorts; e.g. the practice has type 1, type 2 and GDM registers in place
- a systematic approach is employed to support immediate registration of all patients when diagnosed with diabetes with the NDSS
- the approach to prevention and detection includes the systematic use of tools such as AUSDRISK and Absolute Cardiac Disease Calculator patients are supported to achieve clinical targets with an annual series of check-ups under the Diabetes Annual cycle of care (ACOC).

RISK ASSESSMENT TOOLS

AUSDRISK

The Australian type 2 diabetes risk assessment tool (AUSDRISK) is a short list of questions to assess a persons' risk of developing type 2 diabetes over the next five years. The self-reporting assessment tool can be completed by the patient or with a health professional. Systematic use of the tool in assessing patients at risk of developing type 2 diabetes is recommended, for example screening every 3 years from the age of 40 years (www.diabetesaustralia.com.au/risk-calculator).

Absolute Cardiac Disease Risk Calculator

Cardiovascular disease is the leading cause of death in people with diabetes, making assessment of CVD risk is a vital part of diabetes care. The Australian absolute risk calculator combines several risk factors to calculate a risk score (expressed as a percentage), which is a person's chance of having a CVD event such as a heart attack or stroke in the next five years (www.cvdcheck.org.au).

Free online courses are available on the Guidelines for the management of absolute cardiovascular disease risk (see www.apna.com.au and www.heartfoundation.org.au).

REGISTRATION WITH NATIONAL DIABETES SERVICE SCHEME (NDSS)

Ensure patients with diabetes are registered with the NDSS (www.ndss.com.au) by completing and signing an NDSS registration form. Registered patients will have access to diabetes education programs and support. Diabetes Queensland provides a range of education and support services (www.diabetesqld.com.au).

HEALTH ASSESSMENTS

Health assessments have an important role in detection and prevention. Several MBS items support general health assessments, which can be applied systematically in the general practice setting and used across the diabetes care continuum. Assessments are time-based, within either brief, standard, long, prolonged consultations:

- Type 2 Diabetes Risk Evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK)
- people aged 45-49 years who are at risk of developing chronic disease
- people aged 75 years and older
- health assessment for Aboriginal and Torres Strait Islander people.

DIABETES ANNUAL CYCLE OF CARE

The annual cycle of care is an important indicator which provides a measure of the clinical management of diabetes according to national guidelines preventing or delaying the onset and/or progression of diabetes related complications. It is a detailed set of client management steps by general practice. Cycle of care items:

- check weight, height and calculate BMI as part of the initial assessment (6 monthly)
- check weight and waist measurement at subsequent visits (6 monthly)
- blood pressure (6 monthly)
- foot assessment (6 monthly)
- assess diabetes targets by measuring HbA1c (12 monthly)
- pathology for eGFR (12 monthly) (check for kidney disease)
- pathology for total cholesterol, triglycerides and HDL cholesterol (12 monthly)
- check for microalbuminuria (12 monthly)
- provide self-care education regarding diabetes management (12 monthly)
- review diet – provide education about healthy food choices (12 monthly)
- review levels of physical activity –provide education about appropriate levels of physical activity (12 monthly)
- check smoking status – encourage cessation of smoking (if relevant) (12 monthly)
- medication review (12 monthly)
- comprehensive eye exam results from optometrist (2 yearly)
- check emotional health.

Note: Waist measurement is now considered the standard indicator for obesity and should be recorded as least six-monthly. Other considerations: annual ECG, immunisation for influenza vaccine and pneumovax, mental health review considering diabetes distress/depression.

A Practice Nurse/AHP can complete the majority of the ACOC activities. Where referrals to other health professionals such as dietitian or podiatrist have occurred, data from that consult can be used to inform the ACOC, it is essential that the data is correctly coded in the patient file. To ensure this evidence is accessible in the practice, a feedback letter should be received from the allied health professional providing treatment. (This is an essential part of MBS item billing for Team Care Arrangements).

6. EMBEDDING CONTINUOUS QUALITY IMPROVEMENT

Embedding quality improvement strategies into daily workflows builds practice capability to deliver systematic diabetes care. Examples include:

- scheduled in-house quality improvement training in the use of the Model of Improvement including Plan, Do, Study, Act (PDSA) cycles
- quality improvement strategies regularly tabled at practice meetings
- identification of diabetes related quality improvement goals for the practice
- establishing a practice workflow for diabetes patients that will ensure the practice provides individualised care planning for that patient
- confident use of clinical information systems (such as Best Practice/Medical Director) and data management programs such as CAT4Plus/TopBar to understand the whole of practice diabetes patient population.

EXTENDING DIABETES CARE THROUGH CLINICAL UPSKILLING

Foot assessment

Diabetes related foot complications may be prevented with self-care and regular foot checks provided with an Annual Cycle of Care. Professional development can extend the role of doctors, Aboriginal Health Practitioners, or Nurses to perform basic foot assessments. Through extending roles within the practice, one of the two scheduled annual checks can be conducted within the practice, referring complications and the second annual check to a podiatrist (which will include the Doppler probe to test peripheral arterial circulation) Courses of 1 or 1.5 days in length are available to ensure practice staff have the skills to assess, manage and refer.

Eye exams

Diabetic retinopathy is the leading cause of preventable blindness in adults. Early detection and treatment may prevent vision loss. Equipped with a nonmydriatic digital retinal camera, Doctors, Aboriginal Health Practitioners, or Nurses can be trained in taking images to a standard suitable for assessment, increasing services where there may be limited access to an Optometrist or Ophthalmologist. Images are then referred for reading. In addition to this expanded role, with further training, GPs may review the images to detect the presence or absence of retinopathy, referring on as required.

MODEL FOR IMPROVEMENT INCLUDING PLAN-DO-STUDY-ACT (PDSA) CYCLES

This approach is used to improve processes, implement change and is a simple measurement tool to monitor the effect of change over time. Change ideas for PDSA cycles can be created from across the diabetes care spectrum, for example:

Systematic and proactive care

- Increase the number of diabetes annual cycle of care item numbers of 20% within six months.
- Develop and use a recall and reminder system that works to send recalls and reminders to meet best practice care and policy by 1 August.
- Identify all patients who have been coded with diabetes but have not had a HbA1c recorded within the last 6 months using Cat4 plus tool filters.
- Target 60% of eligible patients on the Diabetes Register to be billed a GPMP Item number 721 by 1 August.

Self-Management

- Over the next 3 months the practice team will work toward a common definition of what is meant by diabetes self-management.
- Within the next 4 months the team will identify the preferred resources for clinicians to provide to patients as education materials to support patient self-management.

7. QUALITY DATA

Effective use of data in the general practice setting is essential to patient centred care and continuous quality improvement. When used well, data can assist practice staff to understand the risk factors and help guide clinical prioritisation and decision making, providing patients with best practice strategies for diabetes care. Examples include:

- use of data to optimise business performance, such as use of MBS Chronic Disease Management items
- review of trend data supplied by WQPHN monthly data reports to track patient population and identify areas for improvement
- maintaining a Diabetes Register using clinical information system (e.g. Best Practice/Medical Director) or Cat4Plus tool to provide practice diabetes population, listing all patients with type 1, type 2, or gestational diabetes. This allows tracking of patients' clinical status and their need for ongoing care. Consistent application of policies and procedures will ensure the register lists active patients and remains accurate and up-to-date
- the whole practice team understand the processes to maintain clean and quality data, e.g. coding new patients, updating existing patients, and a process is in place to regularly validate and check the accuracy of the register
- practice data is used to identify patient eligibility for Health Assessments (MBS) and for prevention action, (e.g. meet eligibility criteria for lifestyle modification programs).

RECALL AND REMINDER SYSTEMS

A systematic recall and reminder system for patient appointments will ensure patients with diabetes receive appropriate and timely care that matches the schedule of their care plan and annual cycle of care. A team approach is required to monitor and maintain these systems.

TOPBAR (PENCS)

Automated information tools such as Topbar Apps can help practice staff increase the effective use of data. These Apps can be set up, for example, to provide a prompt to a GP and Practice Nurse/AHP during a patient consult of that patient's eligibility to a program, such as My health for life program, or to their availability for an MBS item, such as a Health Assessment. Other applications can help practice staff opportunistically capture missing data.

8. DIGITAL HEALTH

Use of digital systems can increase health service effectiveness and efficiency and may impact positively on patient outcomes. Examples include:

- timely access to patient records such as Shared Health Summaries and Discharge plans via the My Health Record. Practice uses a consistent and planned approach to uploading summaries
- secure sharing of personalised care plans across teams
- use of population health data to inform quality improvement and resource allocation
- increased access to consultations via telehealth (phone or video)
- remote monitoring via telehealth/telemedicine systems
- electronic sharing of online resources via digital patient education platforms such as GoShare
- use of an online patient portal
- use of HealthPathways – a clinical portal that enables GPs and practice staff access to local assessment, management and request information on a range of conditions
- secure messaging, e.g. Health Link, Medical Objects to transmit information.

MY HEALTH RECORD

My Health Record enables health professionals to view patient's health records such as discharge summaries and upload clinical information in the form of shared health summaries. Establishing roles and responsibilities within the Practice teams will ensure consistent use of the My health record tool.

9. INFRASTRUCTURE

- Consult rooms are set up so that workflows are standardised including access to shared clinical space.
- Systems are in place for case-conferencing, and telehealth.
- Scheduling supports effective patient flows (e.g. Practice Nurse to GP) reducing wait times.
- Skilled workforce with access to professional development and training.
- Health professionals have access to Clinical Guidelines such as General Practice Management of Type 2 Diabetes (RACGP); Guidelines for Preventive Activities in General Practice (Red Book) (RACGP), Putting Prevention into Practice (Green Book) (RACGP).

10. PERFORMANCE

Effective business planning is essential for long term practice sustainability. Every practice is different. WQPHN is working with practices to prepare individual Practice Performance Analyses. This will assist practices review performance goals and targets, understand trends, and identify and measure the results of improved health intelligence, data, digital health and continuous quality improvements changes. Underpinned by stable performance, practices can offer people living with diabetes, high quality workforce, efficient care delivery, and improved patient experience and outcomes.

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WESTERN QUEENSLAND
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Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community. We pay our respect to them and their cultures and to elders past and present.