Strengthening Diabetes Care Across Lower Hume

Introduction

Chronic diseases are the leading cause of death, disability and illness in Australia. *The Chronic Care Model* provides an evidence-based approach to systematically improve care at the community, organisation, practice and patient levels.

Goal

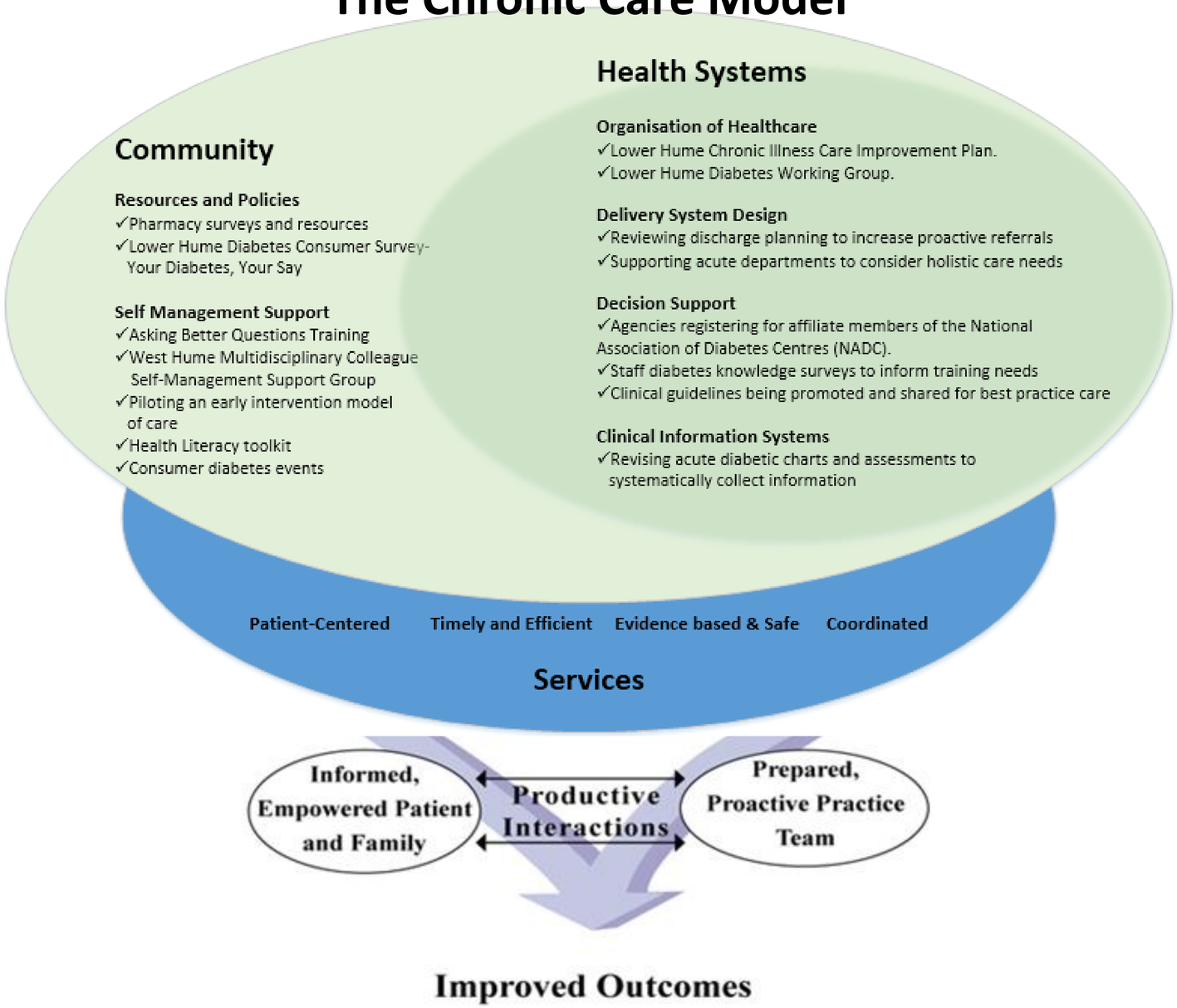
Improve chronic illness care for consumers with diabetes throughout Lower Hume.

Background

In 2014 member agencies completed the Assessment of Chronic Illness Care (ACIC) to evaluate current practice against the domains of the Chronic Care Model. The results informed the *Lower Hume Chronic Illness Care Improvement Plan 2014-2016* which pilots improvements on the regional chronic care priority of diabetes.

Diabetes complications are the leading cause of avoidable hospital admissions in Lower Hume (46.4%) and across the state (45.8%). The rate of admissions for diabetes complications has increased from 11.8 to 19.5 between 2004 and 2014, and average bed days for diabetes complications have increased from 4.6 to 6.8 days.

The Chronic Care Model



Developed by The MaColl Institute

Methodology

Lower Hume Chronic Illness Improvement Plan 2014-2016 outlines agreed actions across each of the domains of the chronic care model for comprehensive systems change. Agencies work independently to test out changes and regularly share results and resources through monthly Service Development Collaborative (SDC) Meetings.

A sub-group of the SDC, the Lower Hume Diabetes Working Group was formed to progress collaborative work including pharmacy and community engagement.

Results 2014-2015

- Collaborative work is enabling more efficient use of resources to achieve common goals.
- Partnerships with pharmacies have been formed.
- Chronic illness care is becoming recognised as a priority within agency planning.
- Agencies are piloting different models of care including an early intervention program and telehealth consulting.
- An average of 86% of participants agreed that the first three meetings of the West Hume Multidisciplinary Colleague Self-Management Support Group increased their confidence to provide self-management support.

Lower Hume Primary Care Partnership

Next Steps

The Chronic Illness Care Improvement Plan was reviewed in October. Priorities for 2016 include monthly presentations at SDC meetings, utilising consumer survey findings to develop local pathway and integrated processes, engaging GP's in local pathway development, pharmacy training and continued communication, continuing to encourage and support e-referral, implementing the Health Literacy toolkit, and coordinating General Care for Diabetes training across the catchment.

"For myself the main impacts of our diabetes collaborative has been: 1) gaining knowledge of additional supports and services I can refer clients to, and 2) Improvement of my own practice through discussion and collaboration. PCP has been a leading factor in initiating, co-coordinating and supporting this collaborative."- Diabetes Nurse Educator.