Integrated Model of Diabetes Type 2 Patient Care

Southern Grampians & Glenelg Primary Care Partnership

Introduction

•Coordination of care for Type 2 diabetes has been shown to improve clinical outcomes and is a priority for all Australian governments.

•In Hamilton, a rural Victorian town of 9,400 people, the Primary Care Partnership, Otway Division of General Practice, Western District Health Service and General Practitioners, developed a practice nursing role to enhance care coordination for Type 2 diabetes.

Method

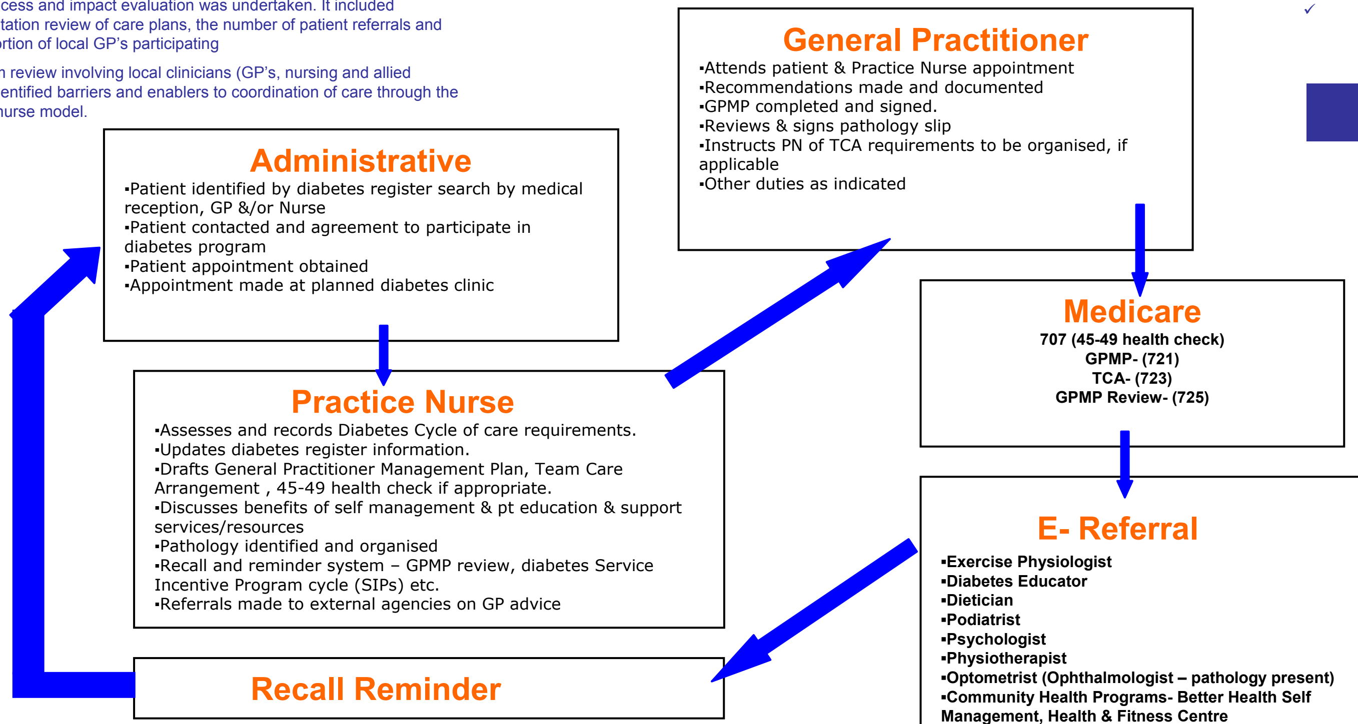
•A multidisciplinary Steering Committee oversaw the planning, implementation and evaluation of the strategy. A Clinical Nurse Educator from the Division worked with upskilling the Practice Nurse.

•Both process and impact evaluation was undertaken. It included documentation review of care plans, the number of patient referrals and the proportion of local GP's participating

•A system review involving local clinicians (GP's, nursing and allied health) identified barriers and enablers to coordination of care through the practise nurse model.

Ms Joy Dore, Practice Nurse, Hamilton Medical Clinic, Group education & client assessment WDHS

Hamilton Clinic Integrated Type 2 Diabetes Management Pathway



Results

•Over a 7 month period a Practice Nurse was employed 4 hours/wk
•45-49 Health Check - 8 new diagnosed Type 2 diabetes patients detected
•GPMP completed (include Care Plan Review) 27 episodes
•Multidisciplinary Referral including review 44
• DSME - 1:1 or Group 26
• GP Participation Rate 60% (9)

System Review of care coordination through a PN model included : -

Barriers :-

- appointment cancellations,
- GP's limited referral to practice nurse,
- GP's not available and
- billing issues e.g. administrative staff not aware of Medicare item no.s

Enablers :-

- ✓ a documented pathway (pictured)
- ✓ personal communication to all GPs,
- ✓ GP database search and targeting eligible patients,
- ✓ IT systems including templates added into clinic software and
- ✓ systematic patient recall and reminders

Conclusion

The addition of a part-time nurse into a rural General Practice was successful in facilitating and integrating service provision and coordination of care for people newly-diagnosed with Type 2 Diabetes. As the method employed to enhance care coordination utilised services which can be rebatable through the Medical Benefits Scheme (MBS), the model is sustainable and is planned to continue. The practical learnings from the development of this model will benefit rural and regional health service providers throughout Australia.

For more information, contact:
Fiona Heenan
ICDM Coordinator
Southern Grampians & Glenelg
Primary Care Partnership
Mobile 0408 528 108