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The CCHS Diabetes Service: Catching people falling through the cracks

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Caulfield
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Part of **AlfredHealth**



Aim of project:

- Increase access to inter-disciplinary primary care services for clients with type 2 diabetes
- Optimise client's skills and confidence to self - manage



Method:

1

Establishment of CCHS Type 2 Diabetes inter-disciplinary team (Aug 2017)

- Credentialed Diabetes Nurse Educator (CDNE)
- Dietitian
- Exercise Physiologist (EP)



CDNE DIET EP CLIENT

2

Initial Assessment: Baseline

- Comprehensive joint assessment & care planning
- Prior attendance to community diabetes services ?
- Problem Areas In Diabetes (PAID)
- Self-Efficacy for Diabetes (SED)



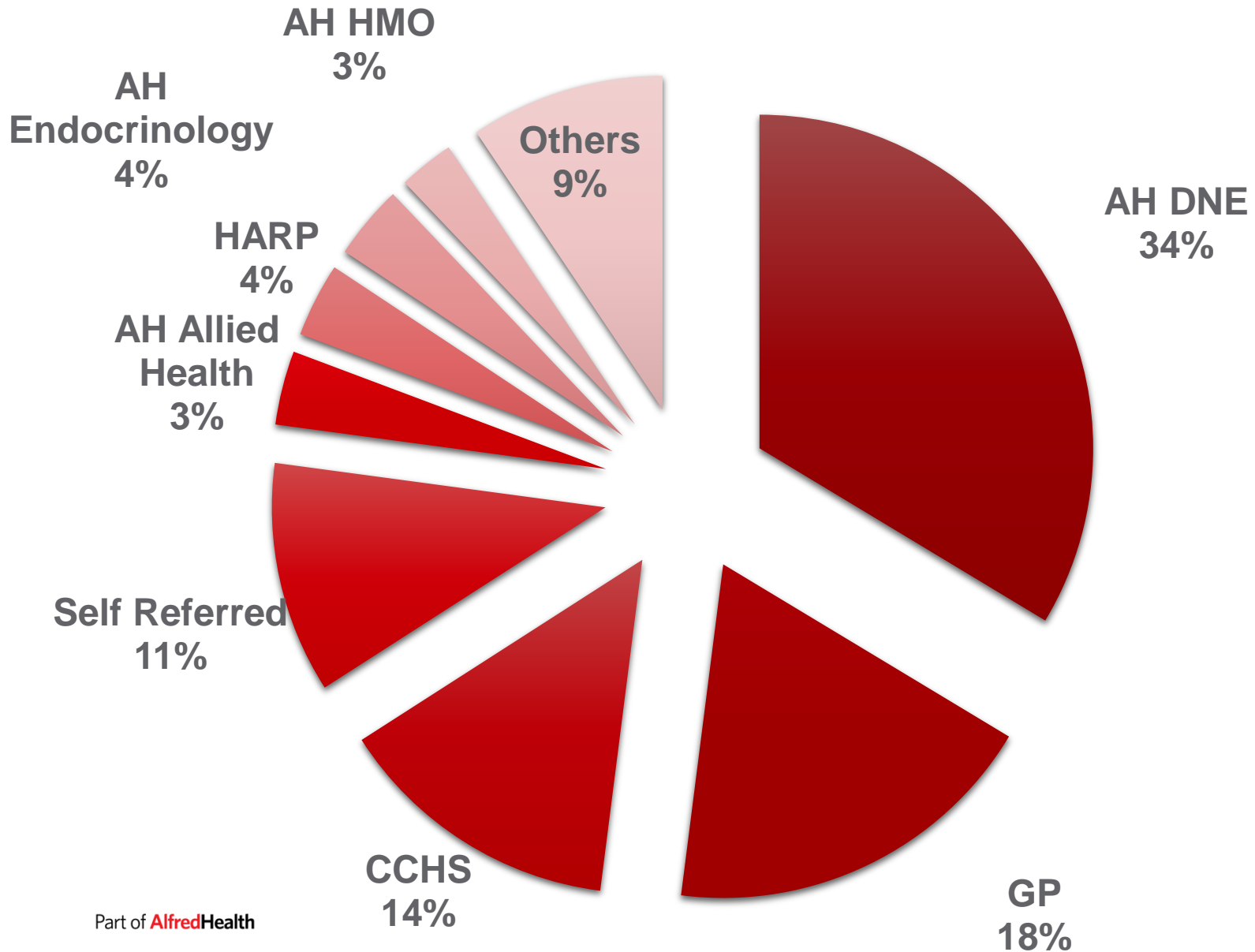
Individualised program



3

Client: 3 month team review

Client referral sources



Results: (Aug – May)

- Majority of clients had no prior community access to diabetes services (n=137)



- X A lack of clear goals for diabetes care (PAID)
- X Worrying about the future & possibility of serious diabetes complications (PAID)
- X Least confident in ability to exercise regularly (SED)

Results continued:

3 month review (n=56)

- ✓ Clear goals for diabetes care (PAID)
- ✓ Feeling more encouraged with management plan (PAID)
- ✓ Confidence improved in all areas (SED)



- Confidence in managing blood glucose levels



- Ability to exercise regularly
 - Managing blood glucose levels when exercising



- Knowing when to see the doctor for diabetes related issues



Client Satisfaction = Net promoter score of 85

Referrer Satisfaction = Net promoter score of 68

A score of 50+ excellent; 70+ world class

“..most positive diabetes related experience since being diagnosed with diabetes 30 years ago”

“The team were a massive help and I walked away **feeling a million dollars better!”**

“I feel empowered”



“I have started exercising!”

“Feel more positive and feel like I can manage my diabetes which I didn't feel before”

“My fridge has changed! Vegetables are now the central things in my fridge.”

“I learned a lot about diet, exercise and monitoring blood sugar levels”

“I'm now in a better place to make decisions about my health as I am better informed”

Challenges & Barriers:

- Marketing service to GP's
- Uptake of group education & group exercise classes
- Lower uptake of EP in the first 2 months of the program
- Completion of questionnaires (72%)



Learnings:

- Interdisciplinary assessment process
- Integration of an EP screening assessment at initial appointment
- GPs – cost, team approach, referral, CCHS allied health



Conclusion:

- Clearly bridging the gap in the local community:
by increasing access to primary care diabetes services



- Clients have improved confidence to self-manage their diabetes following attendance at the program



Acknowledgements:

South East Melbourne Primary Health Network

CCHS Team

Steering committee

Consumer Engagement and participation team

Referrers

Clients