Southern Melbourne Primary Care Partnership

Diabetes Pilot Project 2016 – 2017

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Diabetes Pilot Project Officer

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Acknowledgment of partners

Southern Melbourne Primary Care Partnership would like to acknowledge the following partners who contributed to successful outcomes of SMPCP Diabetes Pilot Project.

SMPCP Diabetes Pilot Steering Committee

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Ailsa Gregory – Southern Melbourne Primary Care Partnership
Terry Lazzarotto - Southern Melbourne Primary Care Partnership
Angela Minnis – Connect Health & Community
Marg Ryan – Central Bayside Community Health Services
Debra Starr - Central Bayside Community Health Services
Phil Williamson – Consumer Representative
Kerryn Woolley – Alfred Health
Sue Wyatt – Alfred Health

Diabetes Clinical Group

Mary Green – Connect Health & Community
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Tracy Orr – Star Health
Marg Ryan – Central Bayside Community Health Services
Sue Wyatt – Alfred Health
Maggie Stewart CDE-RN
Sue Conway - Bolton Clarke

Executive Summary

Southern Melbourne Primary Care Partnership (SMPCP), Service Coordination & Integrated Care members recognised the need to develop systems and processes to enable patients with type 2 diabetes to access appropriate and timely services when requiring insulin initiation across their catchment.

A Diabetes Pilot Steering Committee was established inclusive of local key stakeholders. At the commencement of the project a number of barriers and enablers were identified by this committee.

An operational plan was developed to address the needs of the project's anticipated outcomes with due consideration of the barriers and enablers.

A Clinical Group of key Credentialed Diabetes Educators –Registered Nurses (CDE-RNs) was developed to guide the clinical component of the pilot by the steering committee.

The project targeted GPs that referred frequently to the community health diabetes services and the Alfred Health Diabetes services to develop pathways to increase referrals into the primary care setting.

The project results indicated that referrals positively changed direction to benefit the patients' ease of access to a timely service. Referrals to the acute sector from GPs for uncomplicated care decreased with an equivalent increase across the primary sector.

An injectable medication referral tool for insulin authority for patients being referred by GPs and Alfred Health was developed to assist in insulin initiation within primary care. The document also provided a direct contact to the referring person should treatment changes be required.

Evaluation of the patients, GPs, CDE-RNs and Alfred Health staff involved in the pilot indicated that the pilot enabled referrals to meet the patients' expectations and lessen the burden on the acute sector. While referral numbers were low, adoption of the systems and processes by all services was positive and should continue to grow. It is expected that the Clinical Group will continue to meet regularly with the aim of building on the successful outcomes of the project.

Summary of Findings and Recommendations

The SMPCP diabetes pilot project was formed as a committed partnership influenced by key stakeholder and community members wanting to address suitable referral pathways for patients with type 2 diabetes across the SMPCP catchment.

Minimal resources such as time and personnel did not reduce the impact of the steering group to implement a series of changes across the catchment.

Limitation of the capacity to evaluate relevant project data prior to commencement of the pilot impacted on the evaluation outcomes.

Unexpected findings such as the eagerness of GPs to refer patients to a local collaborative primary care diabetes service and the need of a referral tool for insulin initiation improved the outcomes of the pilot.

The findings of this report supports the need for an integrated diabetes service, the consistent need to regularly engage with general practice and the collaboration across the catchment of clinicians.

A number of recommendations have been provided to explore further opportunities to embed pathways across the catchment to increase the referral of more complex patients into community services rather than maintain them within the acute setting.

A key recommendation was to enhance and maintain continuous quality improvement by streamlining and integrating community services for optimal care delivery, for example sharing of Alfred Health's patient management systems such as the Cerner® system.

Glossary

ADEA - Australian Diabetes Educators Association

Alfred Health – An acute and or tertiary hospital within the SMPCP catchment

CBCHS – Central Bayside Community Health Services

CCH – Caulfield Community Health

CDE –RN - credentialed diabetes educator – registered nurse

Cerner® system– the Cerner® electronic medical record (EMR) is an integrated database that provides a comprehensive set of capabilities. It was created to allow healthcare professionals to electronically store, capture and access patient health information in both the acute and ambulatory care setting. Used within Alfred Health.

GD - gestational diabetes

GP – general practitioner

HbA1c – abbreviation for glycosylated haemoglobin. This is measured in the blood and reflects the average blood glucose over the lifespan of the red blood cells containing it. HbA1c is regarded as the gold standard for assessing glycaemic control. HbA1c is also known as A1c.

ICDM – Integrated Chronic Disease Management

Injectable products for diabetes– for this pilot project this refers to insulin, Byetta, Bydureon , Victoza , Saxenda (type 2 diabetes and pre diabetes)

MOU – Memorandum of Understanding

PM – practice manager

PN – practice nurse

RACGP – Royal Australian College of General Practice

RN – registered nurse

RDNS – Royal District Nursing Service *NOW* Bolton Clarke

SMPCP - Southern Melbourne Primary Care Partnership

Background

Primary Care Partnerships are a Victorian Government initiative aimed at providing access to services that improve continuity of care across the state. These partnerships are designed to improve the coordination of services, making disease prevention a standard procedure for all patients, championing integrated health and fostering partnerships with key stakeholders.

In the 2013-17 SMPCP Strategic Plan, diabetes was identified as a partnership priority and, as a result, the SMPCP Diabetes Pilot Project evolved.

SMPCP Service Coordination and Integrated Care Steering Committee (SCIC) identified a need within their catchment pertaining to diabetes.

Community health services, Alfred Health, regional Diabetes Educator (DNE) specialist group, RDNS, consumers needed to improve the outcomes of people with diabetes in this region through a sustainable, and evidence based clinical pathway enabling patients to receive the most appropriate care in the most appropriate place and time.

Why

Diabetes is a complex condition which can result in long term complications. Diabetes is identified as a priority condition under Victorian Public Health and Wellbeing Plan 2011-2015 (VPHWP)

Diabetes complications are the top reason for admission to hospital in Victoria and across the SMPCP catchment.

Ambulatory Care Sensitive Conditions (ACSC) are those for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management. Diabetes complications is one such condition. Admission for diabetes complications for LGA areas of Glen Eira, Kingston and Port Phillip are high.

The subacute system is overwhelmed with referrals and ongoing care demands that could be serviced adequately within the community. For example, patients with type 2 diabetes requiring insulin initiation and stabilisation and patients with existing management plans are being referred to and receive ongoing management by Alfred Health when they could be managed in the community or primary care setting. Many consumers also report that they find accessing the Alfred difficult and would prefer local community services for routine ongoing diabetes care.

Commencement of SMPCP Diabetes Pilot Project

The catchment's Diabetes Educator group which includes Alfred Health and Community Heath members identified a pressing need for SMPCP partners to:

- agree to differentiation of diabetes educator roles between subacute and community
- articulate a clear referral pathway for people with diabetes
- identify and address service system requirements for implementation
- implement the referral pathway in a sustainable manner which enables the service system to deliver timely and appropriate care in a local community setting for the consumer

The SCIC established a workgroup to develop the project brief. It aimed to be inclusive of acute and community health providers (including CDE-RNs). It was proposed that the project would progress as a pilot across three Community Health Services and their associated General Practice clinic/s. Although the project was a pilot, future sustainability of the eventual model was a key deliverable.

Development of Diabetes Pilot

Objective

The project was established to create sustainable system changes across the catchment or recommend such pathways to enable patients with type 2 diabetes to receive timely and appropriate insulin initiation at a convenient location to the patient.

Aims

- To improve the population outcomes of consumers with type 2 diabetes who require insulin initiation in the SMPCP catchment.
- To identify the patient flow for consumers with type 2 diabetes in the SMPCP catchment in order to identify enablers and barriers for consumers, GPs and services.
- Establish a pilot for insulin initiation with local GPs in conjunction with community services and evaluate a sustainable, evidence based clinical pathway for people with diabetes in the SMPCP region including:
    - Work with key stakeholders to establish line of referral and triage of patients through documented pathways.
    - Increased number of referrals to Community Health Diabetes Educators from GPs.
    - Ensure referrals are redirected from Alfred Health to Community Health Diabetes Educators as appropriate and therefore reduce the number of inappropriate referrals seen by Alfred Health.

Methodology

The SMPCP Diabetes Pilot Steering Committee engaged stakeholders, CDE-RN, a consumer and a general practice clinician. Terms of Reference established the purpose and ongoing role of the committee for the length of the pilot.

Early in the pilot the Steering Committee members recommended a Diabetes Clinical Group be established by engaging the current diabetes specialist interest group for this role.

The groups worked effectively to move the project into the required space to achieve the desired outcomes within the limited time frame.

Engagement with General Practice summary

The length of the pilot was too short to fully embed the systems and processes of referral change in general practice but initiation of the engagement process did occur.

Multiple contacts were made to general practice via telephone, email and face to face visits. Many indicated they had little time or actual confidence to commence insulin within their practice.

General Practice, while willing to adopt new practices, can take time to actually embed the change within their practice. The project served as a pathway to change but this must continue through the clinicians within community health as a reminder of available services.

Several clinics referred into the service but the referrals were slow and a constant reminder of the service availability is necessary to embed the change. This will be achieved through feedback on patient care from clinicians, verbal contact about patients to clinicians and positive feedback from the patients.

Over 72 practices were contacted with subsequent meetings with practice personnel, at the time of writing this report. To date, 85 referrals had been made directly to community health. Each referral is likely to generate further referrals as the feedback process continues to occur.

Clinicians suggested ease of access to the referral tools on service websites would be of benefit to GPs but this was not achievable within most services within the timeframe of the pilot.

Once the Pilot was established, Alfred Health put in place a referral system for patients that had come from general practice that were referred for advice but were then referred to community health services. A ripple effect occurred with other non-injectable referrals being referred out to community health.

GP referrals were slow to grow but an increase across the board of injectable referrals and general referrals was observed. As long as the clinicians feedback the patient's status to the GPs these referral should continue to increase over time.

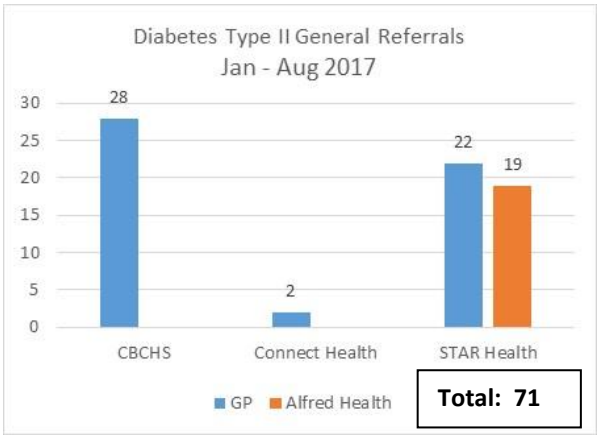


Figure 1: General diabetes type 2 referrals to community health

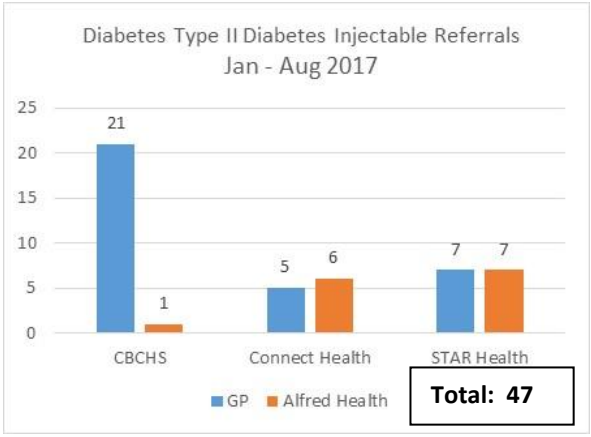


Figure 2: Diabetes type 2 injectable referrals to community health

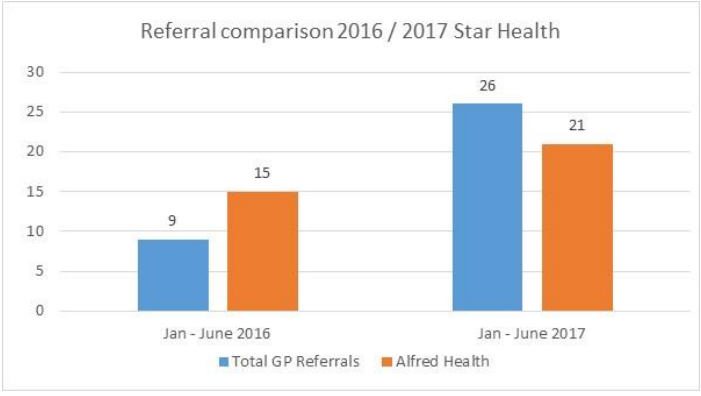


Figure 3: Star Health diabetes Type 2 referrals 2016 vs 2017

(Figures 1&2) As indicated by above a total of 118 patients with Type 2 diabetes were referred by GPs and Alfred Health to the community health services within the pilot project. While 71 of these referrals were for general diabetes services a total of 47 referrals were specifically for injectable medications.

(Figure 3)From the baseline data (Jan – June 2016) there was a total of 24 patients referred by GPs & Alfred Health to community health providers for diabetes self-management support. During the pilot project from (Jan-June 2017) there was 47 such referrals which represents a 95% increase by GPs and Alfred Health. The data suggests that GPs are referring more appropriately to community health providers rather than Alfred Health.

Consultation and Engagement

A number of meetings were held with key stakeholders to discuss the project brief and how the project could move forward. Acknowledgement and support of the project's approach was obtained from key partners across the catchment.

Agency representatives and consumers were recruited to provide support through the Diabetes Pilot Steering Committee and the Diabetes Clinical Group.

General practice clinical staff were consulted when necessary to support the development of the project tools.

The Project Officer reported bimonthly to the SMPCP Executive Governance Group.

> "Some referrals came through from GPs receiving emails/faxes on the project "
>
> - Project Officer

General Practice

A communication plan was developed to assist in engaging general practice and to ensure adequate and appropriate communication occurred with this key referring stakeholder[1].

The project officer targeted and engaged general practice initially communicating with frequent referrers to the community health diabetes service. This was then expanded to others as the pilot progressed.

In total 240 emails/faxes were sent to general practices within the catchment to inform the GPs of the availability of the community health CDE-RNs to assist the GP initiating injectable medications with their patients.

A number of clinics contacted the project to ask for a visit and others simply referred to the service. The local Practice Nurse Network was also emailed about the pilot and the referral tool was provided on request. From this, 10 practice nurses requested an electronic copy of the form.

[1] DEPARTMENT OF HUMAN SERVICES 2008. General Practice Engagement in Integrated Chronic Disease Management: A Resource for Primary Care Partnerships. Melbourne.

Over a period of six months, 72 practices were contacted by phone or face to face visits. In total, GPs in 63 of these clinics were seen face to face, in the remainder, the Practice Nurse or Practice Manager was the contact. Faxes and emails were generically sent to 240 practice contacts.

"The pilot has enhanced the GP & PNs knowledge of services provided by community health"
- CDE-RN

One of the CDE-RNs attempted to contact a group of endocrinologists in her catchment but was unable to gain access. A letter was sent but the pilot received no response.

Table 1: Total contact face to face contacts across 72 practices within the three community health centre catchment areas

Total of GP practices contacted	*General Practitioners*	*Practice Manager*	*Practice Nurse*	*CDE-RN's in general practice*	*Endocrinologist Private and Alfred Health*
72	63	27	34	11	5

General Practice Tool Kit

A simple flier printed in various colors was developed to inform GPs of the pilot what it would offer and benefits to general practice and patients (Appendix 1).

A summary sheet on Insulin Initiation – GP Insulin Toolkit, Medication Referral Form and a copy of a Guide for Australian GPs Diabetes Management journal 2014 was provided to GPs at practice visits. All information was aligned with the RACGP General Practice management of Type 2 diabetes 2016-17

GP quote "I find it difficult to spend the appropriate time to engage the patient and discuss issues such as their fears on commencing insulin."

Referral Tools

The Clinical Group identified a need to have a specific Insulin Initiation Referral form to support their scope of practice[2,3].

[2] AUSTRALIAN DIABETES EDUCATORS ASSOCIATION. 2017. *Scope of Practice for Insulin Initiation* [Online]. Available: https://www.adea.com.au/resources/for-health-professionals/guidelines-and-standards/scope-of-practice-for-insulin-initiation/ [Accessed January 2017].

[3] Drugs, Poisons, and Controlled Substances Act 1981.

The forms were developed in line with the RACGP General Practice Management of Type 2 Diabetes 2016 -2018[4] and were checked by GPs, Endocrinologist and CDE –RN's.

Two forms were developed one for general practice and one for Alfred Health clinicians both forms are interactive if used in the referrers' management software (Appendix 2).

Currently the referral forms are sited on the SMPCP website and can be accessed by all partners.

"The referral form provides me with a legitimate medical order signed by the GP"

- CDE-RN

Referral Pathways

Multiple discussions occurred in the development of referral pathways.

The General Practice to Community Health Pathway was developed to encourage GPs to refer directly to community services rather than acute settings or endocrinologists.

The Clinical Working Group has developed this pathway and is available on the SMPCP website as a draft (Appendix 3).

Work commenced on the development of a second pathway for referral from acute health to community health but due to time restraints the pathway was not finalised before the pilot was completed. Meetings have been held with Alfred Health representatives to discuss referral issues and the pathway is currently under review.

Patient Surveys

Six of the patients referred for injectable diabetes medication responded to the entry and exit surveys and five were contacted after commencing therapy and provided feedback.

All patients commented that they felt good on the injectable treatment and were glad they started it. They indicated that the CDE-RNs gave them time to work through the process and were available for questions once they went home. Patients agreed they were happy to attend the appointment in the local community setting rather than travelling to a large organisation which was stressful in its size, access and cost.

The results suggested that this pilot made a real difference for people including:

- Ease of access to service
- Addressed concerns about commencing injectable treatment
- Improved their diabetes treatment
- Five out of 28 patients had significant drops in their HbA1c 4-6 month after commencing injectable treatment at community health

[4] ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS. 2017. *Clincal guidelines: General practice management of type 2 diabetes 2016-2018* [Online]. RACGP. Available: http://www.racgp.org.au/your-practice/guidelines/diabetes/ [Accessed January 2017].

"My GP was able to talk to the diabetes person and see I was doing what I should be doing this made me feel good"

- Patient

"The diabetes nurse explained things and always had time for me "

- Patient

Clinical Group Meetings

The collaborative discussions initiated unexpected outcomes such as the development of the referral tools, ongoing discussions of common policies and procedures across organisations and review of common feedback form.

One clinician acknowledged that the pilot and subsequent discussions had changed her management of patients. She indicated that it had made her more proactive when discussing patients with referring GPs to ensure the patient's best interest.

Acknowledgement that responding verbally as well as in writing was a key point for all the clinicians as this built an important relationship with local GPs that would result in other referrals.

Recognition that the community health CDE-RN's require a direct line of communication to referring doctors to assist in managing patients with complex issues was key to patient outcomes. Access to health services patient management systems was identified as the most suitable long term solution.

A future meeting is planned for the acute CDE-RNs to meet with community CDE-RNs to share their work capacity and roles in the different settings.

"The pilot has redirected patient care"

- CDE-RN

Project Officer

The Project Officer was able to contribute content in an application for funds to set up an Integrated Service at a local community health service and continued to collaborate with the development of the funded project. The Clinicians Group embraced the opportunity to engage the CDE-RN into their group meetings.

The Project Officer attended the local private Diabetes Educator meetings to provide feedback on the pilots' progress. A number of educators asked for a copy of the referral form and plan to use it within their work setting.

Frequent discussions with key persons at Alfred enabled changes across pathways and referrals.

General Practice visits often provided an opportunity to expand on all the services provided by community health. One practice in particular was keen to refer their patients to Central Bayside CHS' DESMOND program as they were well versed with it from having worked in the UK.

Collaborative work with the SMPCP Diabetes Project Officer and Monash Health through their Chronic Disease Strategy 2016-2021 initial action area focus group allowed outreach discussions of this pilot. Ongoing engagement with this strategic work could see the adoption of some of the Diabetes Pilot Project outcomes.

Data collection

It was anticipated that data relating to numbers of patient referrals to community health services from GPs and Alfred Health would be collected prior to the commencement of the pilot. This data would form a baseline for comparison. Unfortunately, due to a number of unanticipated factors, referral data related to the pre-trial period was not universally collected across all pilot sites. These factors included organisational restructure and accreditation.

The steering committee also considered the possibility of collecting retrospective HbA1C data of participating patients for comparison with pilot data. However, it was determined that it was not feasible to collect this data retrospectively due to lack of access to record keeping systems, organisational capacity issues and privacy issues.

Referral data was collected during the pilot and HbA1c data was recorded for a small number of patients. Both sets of data showed positive trends but due to the small numbers collected and lack of baseline information the data cannot be considered significant.

Qualitative data in the form of a survey was collected from GPs, CDE-RNs and patients (Appendix 4) however there were difficulties in collecting this information. Staff responsible for following up the completion of surveys experienced high overall workloads, reduced staff capacity due to employment status (part-time) and leave (long-service) during the period of the pilot. The slow rate of referral initiation contributed to lack of momentum in following up with surveys.

Future projects would greatly benefit from addressing the issues identified with data collection in this report. There is significant potential to build on the initial work established by the SMPCP Diabetes Pilot Project.

Enablers and Barriers

A group process was used to identify enablers and barriers that were recognised by the steering committee and clinical working group in the initial three months of the pilot's roll out.

Time was given at subsequent meetings to discuss the enablers and barriers to ensure they were all addressed or added to as the pilot evolved.

Below is a summary of the identified enablers and barriers and the outcomes associated with them.

Enablers

General practice engagement

- GPs eager to hear about the service and community health services in general.
- Increased opportunity to maintain collaboration and communication with Practice Nurses in the differing roles within diabetes care.
- Acknowledgement by GPs that they find the conversation with patients regarding the need to initiate insulin quite difficult and often the patients prefer/insist on alternative treatment.
- Working collaboratively with community diabetes team supports patient care and end results in a positive manner.

Engagement of Diabetes Educators

- Opportunity for increased communication and collaboration between community and acute sector CDE-RNs through the diabetes pilot project.
- Current community CDE-RNs have a well-developed relationship across the catchment as they meet monthly to support their service outcomes. The project linked into this and was able to build change across the catchment through this connection e.g. referral tools, referral pathways.

Timelines

- The mutual respect and established relationship of the project members provided a sound base for this pilot project to roll out across the catchment.

Outcome of Enablers

The enablers supported the positive improvements in referral pathways and patient care. The collaboration within the partnerships e.g. Alfred health that had been built over some time enabled SMPCP Diabetes Pilot Project to achieve goals very early and reach conclusion within the planned timelines. It demonstrated the value of partnership work as a vital measure of success.

Barriers

A number of barriers to the project's success were identified both in the initial stages and during the implementation phase.

Referral Pathways

1. *CDE-RNs needed clarification of After Hour services availability from local GPs. There was a strong belief that they would be required to be available according to ADEA guidelines.*

   On investigation, the ADEA guidelines for *Managing Insulin Therapy in Ambulatory Care Setting–Guiding Principles* it was noted that this document was not ratified and was considered as only a guideline for clinical care at the time of the pilot[5]. Clarification through ADEA indicated to the Project Officer that the wording of support necessary for the CDE-RN to initiate insulin with the patient had in fact been misread and was not directly required by the CDE-RN. The correct interpretation of the wording was that the CDE-RN needed to ensure that their patients knew where to get advice should an issue arise e.g. identifying the patient's GP out of hours service contact details and ensuring that the patient has this information was considered sufficient support.

2. *Referrals for Insulin Initiation cannot commence at the end of the week (e.g. Friday) as there is no follow up available by community CDE-RNs at the weekend.*

   The CDE-RN at Connect Health and Community's overcame this barrier by setting aside time every Monday to address new patients requiring injectable medication so they were not kept on a waiting list and were not commenced on insulin on Friday's.

[5] AUSTRALIAN DIABETES EDUCATORS ASSOCIATION 2013. The Guiding Principles for Managing Insulin in Ambulatory Care Settings: A Quality Use of Medicines Strategy. *In:* MURFET, G. & AYLEN, T. (eds.) *Managing Insulin Therapy in Ambulatory Care Settings* Chifley, ACT: Australian Diabetes Educators Association.

Other community health services referred the patient directly to the appropriate CDE-RN in order to directly engage the patient in a timely manner.

During visits to general practice by the project officer and CDE-RNs, GPs were also informed that insulin initiation would not occur on a Friday to ensure safety of management of the medication over a weekend.

3. *Referral tools were not in place or not used in accordance to their requirements e.g. community diabetes services were not aware of expiry dates of the insulin medication advice form used by the acute sector*.

   The Clinical Working group developed an Injectable Insulin Medication Referral form that could be used by general practice to refer into community health.

   After consultation with the Alfred Health diabetes team, this form was modified and is currently being piloted through the Alfred Health diabetes team when referring patients to community health for insulin initiation.

4. *Demand from some Intake Services for specific information lead to patients not being referred to the most timely and appropriate service for the patient*.

   The issue was discussed at the clinicians meetings but needs further collaborative work to ensure the referral pathway to community services flows and ensures easy access for the patient.

Information systems

1. *Pathway to contact medical support through diabetes registrar at Alfred Health is not currently defined for community CDE-RNs to enable timely feedback on patient needs as required.*

   The community CDE- RNs have an email they can use for to request feedback for medical support although this can still take time for a reply to be received.

2. *Lack of connectivity across the acute and community sectors with patient management systems means clinicians cannot access all patients' information when required.*

   To support communication across services an MOU was established between Star Health and Alfred Health to enable their CDE-RN access to the management system to ensure a timely response from key clinicians when required. This was a lengthy process and at the time of writing this report access has only been provided to one clinician at Star Health and does not include other diabetes services project partners.

   However, key personnel have been identified to contact for all community CDE-RNs within the project for assistance with medication changes.

Timelines

1. *A sudden increase in referrals to the CDE-RN will increase their workload. This may hinder the timely response to referrals.*
   Early in the project, Star Health experienced a sudden increase in patient referrals for insulin initiation. To support this increase the integrated diabetes team approach was put in place. As

the referrals increased the dietitian became the first clinician to meet with the patient to reduce the urgent workload of the CDE-RN which maintained the patient centered approach.

2. *Lack of engagement by organisation members to work collaboratively with a project they had proposed.*

   At times the progress of the project was limited by the lack of support by key management staff and health providers which prevented work rolling out in a timely manner. Due to leave by multiple clinicians it was difficult to bring all the parties together to outline the pilot and evaluation needs. Consequently obtaining key data on referrals related to the pilot work was not fully clarified or obtained from some centres e.g. patient feedback, actual notification of referrals.

   There was limited opportunity to drill down into the roles of the acute and primary CDE-RNs which require a consultative discussion on the diversity and commonalities of the roles.

3. *Commencement of the project late in the year could create barriers to the engagement of general practice and patients who may be away on annual leave*

   The project plan was developed to address a number of concerns around the timing of the project and the length of the project to ensure the KPIs would be addressed and met in the pilot's time frame.

Summary of outcomes for barriers and enablers

The enablers that were identified at the beginning of the pilot proved to be successful in supporting short and long term outcomes. The collaborative relationship between the partners saw work move forward in most cases in a positive and constructive manner.

At the same time, due to the good will of the partnerships, many of the barriers were positively addressed by the partners to enable the pilot to address key objectives.

Findings

The SMPCP Diabetes Pilot Project identified gaps in the referral process and developed referral tools to support the transfer of information via referral pathways into primary care from multiple agencies e.g. Alfred health, general practice. This ensured Credentialed Diabetes Nurse Educators (CDE-RNs) were provided with adequate information within their scope and legal requirements to commence insulin in tandem with the GP or acute sector with referred patients. The development of the Insulin Initiation Medication Referral form was integral to this improved pathway and is now used widely by general practice, private CDE-RNs and Alfred Health.

Collaborative support of primary care management enabled change to occur across all pilot organisations to ensure patient centered care with diabetes injectable referrals. Key to the success of the pilot was the recognition by the services of the need to address such referrals in a timely efficient way.

The primary care CDE-RNs played a pivotal role across the catchment in enabling their service to build capacity through the partnership pilot with assistance of each organisation's Intake service.

Patients reported being more satisfied when referred to local integrated diabetes services. They stated that they felt more connected, referrals were more cost effective, and their travel time to and from appointments was lessened. While the project has achieved many of the anticipated outcomes it cannot be said that those outcomes have been evenly spread across the catchment.

An even spread of successful outcomes would have required greater ownership of the project by all parties and this was not the case. At times the project was significantly hampered in key areas. Initially there was no capacity for the Project Officer to meet with key clinicians to ensure they understood and could align some of their work to address the project's evaluation and outcomes. Meetings were offered and arranged but clinicians often did not attend. Engagement with the project by a senior clinician had a positive impact. Clinician attendance at meetings improved after the senior clinician from the steering committee stepped in to ensure staff made time available to meet with the Project Officer.

GP engagement was most successful when following a set process e.g. telephone calls, visits, and email follow up contacts to achieve the best outcomes. Collaboration across the services when engaging in this work is vital to prevent overloading the practices and possibly missing opportunities to engage.

Commitment to a Diabetes Steering Committee was made at the commencement of the project by a variety of stakeholders however capacity to attend was affected by competing demands which resulted a low attendance rate.

Referral numbers varied across the services which was more due to conflicting interests within each setting than the commitment of the key CDE-RNs, Alfred Hospital and GPs.

Data collection proved difficult for the centres who had not fully engaged. This was partly through a lack of recording of data as well as an inability to derive data from their systems.

The project met many of its expected outcomes and can demonstrate in a short timeframe of months that referral pathways can be changed and positively affected referrals when processes are developed and followed accordingly.

It was established midway through the pilot that all injectable medications for type 2 diabetes should be referred by the same pathway as insulin to ensure good patient care.

Sustainability

At the commencement of the pilot project the Steering Committee indicated the need for sustainable outcomes from the pilot.

As a partnership pilot it was important to ensure each partner was recognised in their catchment as the point of contact when referring patients through the developed medication referral form, engaging CDE-RNs to meet the GPs and separate information fliers for each center.

The CDE-RN of each service was invited to meetings with General Practice visits where possible. This provided a personal touch which general practice agreed it "provided reassurance to meet who will be looking after my patients."

Meetings across the sector discussed the future direction of referrals and the collaboration of the services to sustain the practice. It was generally agreed that this was required to secure sustainable practice. The Clinical Group plans to continue to meet regularly to address future changes and sustainability of processes established by the pilot and include the recently appointed CDE-RN at

Caulfield Community Health Service as a member. At the time of writing this report this service had received 17 referrals from Alfred via the referral pathway enabled by this project.

Collaborative work with the SMPCP Diabetes Project officer and Monash Health through their Chronic Disease Strategy 2016-2021 initial action area focus group allowed outreach discussions of this pilot. Ongoing engagement with this strategic work could see the adoption of some of the Diabetes Pilot Project outcomes.

Recommendations

- Explore further opportunities to embed the pilot pathways across the catchment to increase the referral of more complex patients that can be managed in the primary setting.
- Enable continuous quality improvement by streamlining and integrating acute and community services for optimal care delivery e.g. open sharing of patient management systems such as the Cerner® system used by Alfred Health
- Provide an opportunity to drill down into the roles of the acute and primary CDE-RNs which requires a consultative discussion on the diversity and commonalities of the roles. It is now very timely to examine this area as the clinicians are working in a mutually agreeable space that would provide a solid ground to approach this work.
- Explore opportunities to partner with both primary and acute care services to conduct diabetes clinics utilising endocrinologists and community teams from tertiary hospitals in the community setting e.g. Create a program like the Carrington IDEAS Program
- When committing to PCP projects, consideration should be given to the implementation of an MOU to ensure partner organisations appoint key staff to the project who will have the capacity to provide time and support to the project as necessitated by project requirements. Appointed staff will have the full support of upper management within their organisation.
- Maintain the established Clinical Network for CDE-RNs across the catchment to promote excellence of care for the patient with diabetes across the SMPCP catchment. Propose a partnership with this group with like clinicians through the Monash Chronic Disease Strategy 2016-2021 approach.
- Work collaboratively with key organisations to develop a referral pathway that addresses minimal data sets of referral information to ensure patients are sent to the most suitable service for them.
- Provide electronic versions of referral tools on each community health service website within the SMPCP catchment for ease of access by external clinicians e.g. GPs, practice nurses
- Continue to create opportunities to build a partnership approach to all aspects of diabetes care for patients with type 2 diabetes.
- Explore opportunities and pathways to inform general practice of changes within primary care to enable greater referrals to the most timely, local and relevant setting .e.g. a shared GP Liaison position across a number of the community health services.
- Future work should look at determining baseline data to establish requirements of the project prior to commencing. This will allow for better pre and post comparison of project data.
- Future work should look at the completion of the acute to community health referral pathway commenced during the SMPCP Diabetes Pilot Project.

Key Deliverables completed for Diabetes Pilot Project 2016-17

- Defined pathways for patients with type 2 diabetes requiring injectable medications from GPs to community health.
- Draft referral pathway for patients referred by GPs to Alfred Health with diabetes requiring insulin initiation that are non-complicated and non-urgent into community health.
- Credentialed Diabetes Educators – RNs maintained their engagement with the project and expanded the group to include the newly appointed CDE-RN at Caulfield Community Health.
- Clinicians group to continue as a consultative group for members practice into the future.
- Memorandum of Understanding was developed and signed off between Alfred Health and Star Health to ensure adequate and timely communication streams between diabetes clinicians.
- Clinicians Group to review and produce common Policies and Procedures for diabetes services.

Appendix 1 – Sample GP Flyer

Insulin Initiation/Byetta/Bydureon *Support* for Patients with Type 2 Diabetes

[Insert Community Health Service] Diabetes Nurse Educator (DNE) is available to **support GPs** initiating insulin.

- ✓ short wait times (1-3 weeks)
- ✓ whole of team approach (we also have podiatry and other therapies)
- ✓ **Local** patient centred care
- ✓ session not counted towards CDM Services- GPMP or TCA
- ✓ low cost: means-tested community health fees apply

Calls from GPs, practice nurses and practice managers are encouraged. For more information, contact Ailsa Gregory on 8587 0148 or **agregory@smpcp.org.au**

www.smpcp.org.au

Appendix 2 – Sample Insulin Initiation Referral Forms

Clear form

Southern Melbourne Primary Care Partnership

Insulin Initiation Medication Referral
send with VSRF

Doctor's stamp

Fax to: Click here to choose service

After Hours Phone: _____

1. Client Details

Date of Birth:

Last Name: First Name:

Address:

Suburb: Postcode:

Contact Number:

2. Pathology/Medical Exam Results

HbA1c (within last month): % Date:

Fasting/Random BGL: mmol/L Date:

Other relevant results:

Please attach pathology lab reports

3. Adjustments to current diabetes medications and/or steroids

4. Insulin Therapy Requested

	Type of Insulin:	Starting Dose:	Frequency:
1.			
2.			
3.			

Guidelines for adjustment only*

Basal (peakless) insulin/Premix insulin			
Average FBG	Dose Adjustment	Average FBG	Dose Adjustment
>10	↑ by 2 - 4 units	6 – 6.9	No change
8 – 9.9	↑ by 2 – 4 units	4 – 5.9	↓ by 2 units
7 – 7.9	No change OR ↑ by 2 units	< 4	↓ by 2 – 4 units

I am aware the Diabetes Nurse Educator will adjust the above patient's insulin doses and review their BGL's according to the orders I have provided to assist in the management and stabilisation of the patient's diabetes.

Referring Doctor's Signature: _____ Date: _____

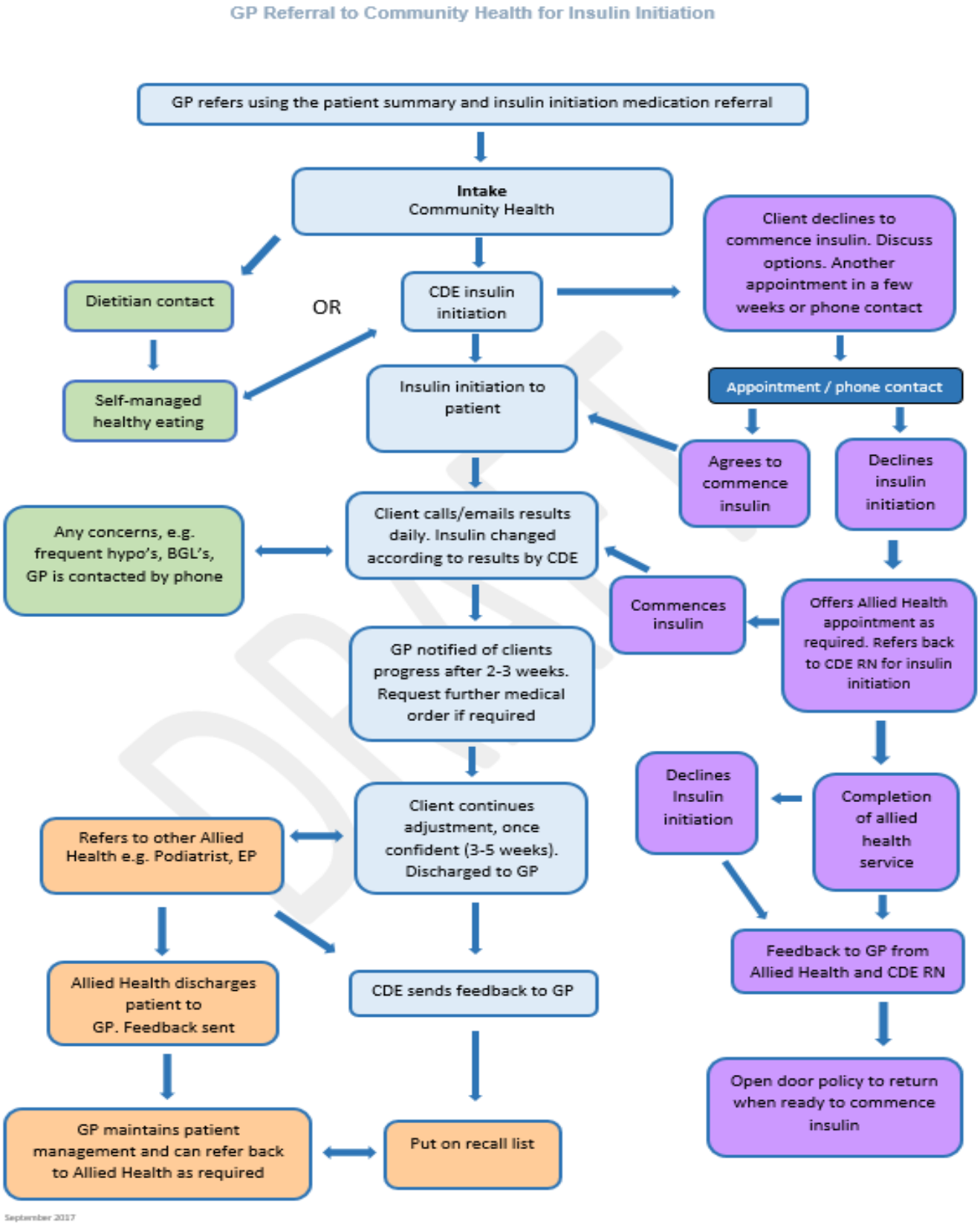
GP/specialist will be contacted by the DNE if hypo/hyperglycaemic etc. events occur.

NB: If insulin has not commenced within 8 weeks from date of referral, please confirm orders before initiation

**See RACGP General Practice management of type 2 diabetes 2016-18 for full adjustment guidelines*

Updated: August 2017

Appendix 3 - General Practice to Community Health Pathway



Appendix 4 – Survey samples

Southern Melbourne Primary Care Partnership	**Diabetes Pilot Project 2016-17** **Injectable Medication questionnaire for CDE-RN**

DATE: _____ /_____ / _____

Please complete weekly when you have Insulin Initiation clients attend

1. Number of patients referred by GP for Injectable Medication Initiation?
2. How easy has it been to get adequate information from the GP on patients to for this episode of care?
3. A. How often have you discussed the patients' treatment with the GP/PN before or after referral? B. What were the issues discussed
4. Are there any changes required to the Diabetes Pilot Pathway to assist patients negotiating the patient journey?
5. What form of communication have you used to advise doctor of patient progress? Please circle: Phone / Email / Letter / Other (please explain):

6. Outline any Barriers or Enablers to the process
Any other feedback

Thank you for completing the questionnaire.

Please email this weekly to Diabetes Pilot Project Officer

Southern Melbourne Primary Care Partnership

Diabetes Pilot Project 2016 / 17
Pre and Post Patient
Insulin Initiation questionnaire

DATE: _____ /_____ / _____

Please complete this questionnaire and return to your Diabetes Nurse Educator

Please circle: **Male/Female**	**Age:**_____

1. How often do you take your blood glucose (BGL)

2. What have your BGL readings been over the past month?

3. Do you know what your BGL should be?

   Yes **No**

   If yes, please give a range_____

4. **Why are people with diabetes asked to test their own BGLs? Please circle one option only.**

   a. To alert them to changes in BGL

   b. To help them make decisions about their exercise and treating "hypos"

   c. It can make people more confident in looking after their diabetes

   d. All of the above

   e. Unsure

5. How do you feel about starting insulin?
Questions 6 – 7 are to be completed after you have started insulin
6. Has your health and diabetes improved since starting insulin? **Yes** **No**
7. Do you feel comfortable about managing your insulin according to your needs? Please circle. **Yes** **No** If No, why not?
8. Do you know who to contact for assistance? Please circle. **Yes** **No** If yes, please tell us who you would contact
Other comments:

Thank you for completing the questionnaire.