NSW Diabetes Forum
#nswdf17
Sharing knowledge, information and experiences
Friday, 24 March 2017
Overview

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW.

We provide expertise in service redesign and evaluation, specialist advice on healthcare innovation, initiatives including clinical guidelines and models of care, implementation support, knowledge sharing and continuous capability building.

Our Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across the NSW Health system. By bringing together leaders from primary, community and acute care settings we promote an integrated health system.

Audience:
This event is aimed at doctors, nurses, allied health professionals and managers that work in NSW health services and consumers contributing to ACI networks.

Please note:
Photographs taken at this event may be published by the ACI for internal and/or external promotion, education or research purposes. If you do not wish your photograph to be taken please notify our staff.

Aims:
The aim of the Diabetes Forum is to provide an opportunity to share knowledge, experiences, and innovation in diabetes management.

Three sessions will explore improving care for people with diabetes:
- requiring hospitalisation
- at risk of diabetes-related foot complications
- living in the community

Cost: Free


Twitter: #nswdf17

Sli.do:
URL: [www.sli.do.com](http://www.sli.do.com)
event code: #nswdf17

For more information please contact:
Anthea Temple
A/Program Manager, Acute Care, ACI
02 9464 4623
Anthea.Temple@health.nsw.gov.au
<table>
<thead>
<tr>
<th>Time</th>
<th>Session/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30 – 9.00</td>
<td>Registration / Tea and Coffee</td>
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<tr>
<td>9.00 – 9.10</td>
<td><strong>Welcome to Country</strong>&lt;br&gt;Uncle Ray Davidson</td>
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<tr>
<td>9.10 – 9.15</td>
<td><strong>Open and Welcome</strong>&lt;br&gt;Prof. Stephen Twigg - Co-Chair, ACI Endocrine Network</td>
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<td>9.15 - 9.30</td>
<td><strong>ACI Update</strong>&lt;br&gt;Kate Lloyd - A/Director, Acute Care, ACI</td>
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<td>9.30 – 9.45</td>
<td><strong>Diabetes Mellitus – Service Utilisation and Impact on Resources in NSW</strong>&lt;br&gt;Mahendra Sharan - Data and Statistical Analyst, Clinical Program Design and Implementation, ACI</td>
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<td>9.45 – 10.05</td>
<td><strong>NSW Diabetes Taskforce</strong>&lt;br&gt;Marina Davis - Network Manager, Acute Care Projects Team, ACI</td>
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<td>10.05 – 10.30</td>
<td><strong>The person at the Centre of Care</strong>&lt;br&gt;Sturt Eastwood - CEO, Diabetes NSW and ACT</td>
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<tr>
<td>10.30 – 11.00</td>
<td>Morning Tea</td>
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**Session 1: Improving care for people with diabetes requiring hospitalisation**

**Convenor:** Barbara Depczynski - Senior Staff Specialist, Prince of Wales Hospital, Co-Chair NSW Diabetes Taskforce In-Hospital Working Group

- St Vincent’s Diabetes Service Transplant and Inpatient Models of Care<br>  **Prof. Jerry Greenfield and Joanne Taylor** - St Vincent's Hospital Sydney Diabetes Service
- The Glucose Management Mpage – An ACI, eHealth, LHD collaboration in eMeds<br>  **Aiden Shi** - eHealth NSW
- Routine HbA1c Testing in the Emergency Department<br>  **Dr. Tien-Ming Hng** - Blacktown Hospital
- Managing Hyperglycaemia in Patients with Diabetes on Enteral Nutrition: The Role of a Specialised Diabetes Team<br>  **Assoc. Prof. Vincent W. Wong** - Liverpool and Fairfield Hospitals

**Session 2: Improving care for people at risk of diabetes-related foot complications**

**Convenor:** Vanessa Nube - Director, Podiatry, Sydney LHD

- Save A Leg: Building Integrated Diabetes Foot Services in Western Sydney<br>  **Clare McGloin** - Blacktown and Mt Druitt Hospitals - Western Sydney LHD
- Current Perspectives on Diabetes-Related Foot Disease in the Aboriginal and Torres Strait Islander Community of NSW<br>  **Matthew West** - Yerin, Galambila and Redfern Aboriginal Medical Services; University of Newcastle and Assoc. Prof. Vivienne Chuter - University of Newcastle
- Access to High Risk Foot Care: Who is Referring and who is not?<br>  **Jessica White** - Sydney LHD
- Diabetes Debridement Study; A Ministry of Health Funded Translational Research Project<br>  **Vanessa Nube** - Sydney LHD

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>11.00 – 12.10</td>
<td>Improving care for people with diabetes requiring hospitalisation</td>
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<tr>
<td>12.10 – 1.20</td>
<td>Improving care for people at risk of diabetes-related foot complications</td>
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<td>1.20 – 2.10</td>
<td>Lunch</td>
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### Session 3: Improving care for people living in the community with diabetes

**2.10 – 3.20**

**Convenor:** Glen Maberly - Senior Staff Specialist, Endocrinology, Program Lead, Western Sydney Diabetes, Western Sydney LHD

- **Wollondilly Diabetes Project: A Population-Based, Integrated Approach for Diabetes Care**  
  *Dr. Rati Jani, Dr. Freya MacMillan and Prof. David Simmons, The Wollondilly Diabetes Programme*

- **Diabetes Care Collaborative**  
  *Daniel Shaw and Maria Jessing, South Eastern Sydney LHD*

- **The AUSDRISK’s Predictive Capacity Needs to be Refined to Determine Appropriate Scoring for Persons with Spinal Cord Injury**  
  *Wendy Jannings - Northern Sydney Home Nursing Service*

- **First Steps Towards an Integrated Care Model for Diabetes**  
  *Prof. Greg Fulcher – Royal North Shore Hospital, Clinical Director Chronic and Complex Medicine North Sydney LHD*

- **The Western Sydney Integrated Care Program**  
  *Prof. N Wah Cheung - Western Sydney LHD*

### Session 4: Knowledge Café

**3.20 – 4.25**

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<table>
<thead>
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| **1.** | The Get Healthy Service Type 2 Diabetes Prevention Program  
*Nageen Ahmed*
  *NSW Office of Preventive Health*
|  |
| **2.** | Empowerment Through Culturally Appropriate Health Education in Type 2 Diabetes  
*Gladys Hitchen*
  *Spanish Speaking Diabetes and Heart Association of Australia, Inc. (SSDHA)*
|  |
| **3.** | Save A Leg: Building Integrated Diabetes Foot Services in Western Sydney  
*Clare McGloin and Sumathy Ravi*
  *Western Sydney LHD*
|  |
| **4.** | AusCDEP: Competency-based Online Diabetes CPD for Health Professionals.  
*Therese Fletcher*
  *Macarthur Diabetes Service, Campbelltown Hospital*
|  |
| **5.** | Hospital Frequent Fliers: Commonalities Seen Between Patients Re-presenting to Hospital  
*Julie Gale*
  *Prince of Wales Hospital*
|  |
| **6.** | The Glucose Management Mpage – An ACI, eHealth, LHD collaboration in eMeds  
*Aiden Shi*
  *eHealth NSW*
|  |

**4.25**

**Co-chair wrap-up**  
*Prof. Stephen Twigg - Co-Chair, Endocrine Network ACI*

**4.30**

**Evaluation / Close**
<table>
<thead>
<tr>
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| **St Vincent’s Diabetes Service Transplant and Inpatient Models of Care**<br>Prof. Jerry Greenfield – Head, Department of Endocrinology and Diabetes and Joanne Taylor – Nurse Manager, St Vincent’s Hospital Sydney – Diabetes Service.  
At St Vincent’s Hospital, Sydney, approximately 25% of hospitalised patients have diabetes. The prevalence varies in different patient groups, with some over-represented due to comorbidities and treatments, such as corticosteroids. The prevalence of diabetes amongst patients on the lung transplant list is 60%. Post-transplantation, up to 80% have diabetes. Based on these findings, we established a dedicated team, comprising an Endocrine Transplant Registrar and Endocrinologist, supported by diabetes educators and dietitians as required, to detect, diagnose and treat diabetes prior to and after lung and other solid organ transplantation. |
| **The Glucose Management Mpage – An ACI, eHealth, LHD collaboration in eMeds**<br>Aiden Shi – Application Specialist, eHealth NSW  
With the wide spread implementation of electronic medication management (eMeds), there was an opportunity to enhance clinical decision support beyond the constraints of paper Adult Subcutaneous Insulin Paper Chart. eHealth engaged the ACI and LHD to develop a Glucose Management review page through applying User-Centred Design principles and an iterative approach. The Glucose Management Mpage improved the viewing ability for displaying temporal relationships between blood glucose and ketone levels with glucose-related medications, primarily insulin, in the eMeds system. |
| **Routine HbA1c Testing in the Emergency Department**<br>Dr. Tien-Ming Hng - Head, Diabetes and Endocrinology, Blacktown Mount Druitt Hospital  
Diabetes is prevalent in Western Sydney. This presentation explores our approach towards the detection of individuals at risk of diabetes when they present to our Emergency Department. In a joint venture with the Primary Health Network, we also describe our early experience in following up on these individuals noted to be at risk. |
| **Managing Hyperglycaemia in Patients with Diabetes on Enteral Nutrition (EN): the Role of a Specialised Diabetes Team (SDT)**<br>Assoc. Prof. Vincent W. Wong - Diabetes and Endocrine Service, Liverpool and Fairfield Hospitals  
Our findings confirmed that there was a role for SDT in managing patients with DM who received EN during their hospital admission. These patients had improved glycaemic control while receiving EN and had better clinical outcomes. |

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<th>Session 2: Improving care for people at risk of diabetes-related foot complications</th>
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| **Save A Leg: Building Integrated Diabetes Foot Services in Western Sydney**<br>Clare McGloan, Senior Podiatrist Blacktown and Mt Druitt Hospitals  
Western Sydney is a diabetes hotspot. The Western Sydney Local Health District needs to be proactive in combating this burden of disease which is often considered to be preventable. A structured district wide diabetes foot screening programme is needed to be established to allow the patient to be screened for diabetes foot risk factors and to accordingly be integrated into local services. |
Current Perspectives on Diabetes-Related Foot Disease in the Aboriginal and Torres Strait Islander Community of NSW

Matthew West – Podiatrist, Yerin, Galambila and Redfern Aboriginal Medical Services and Assoc. Prof. Vivienne Chuter, School of Health Sciences (Podiatry), University of Newcastle

Discussing the current understanding of the nature of diabetes related foot disease in the Aboriginal and Torres Strait Islander community of NSW and how current outcomes translate to service utilisation on a clinical level.

Access to High Risk Foot Care: Who is Referring and Who is Not?

Jessica White - Project Coordinator and Senior Podiatry, Sydney LHD

This project describes an audit of time to referral and who referred to the Concord Hospital High Risk Foot Service and is presented in the context of the need for prompt referral for patients with diabetes related foot ulcers and the effect on patient outcomes.

Diabetes Debridement Study: A Ministry of Health Funded Translational Research Project

Vanessa Nube – Director Podiatry, Sydney LHD

A randomised controlled trial, clinician survey and prospective audit will be conducted across NSW to provide data and evidence for sharp wound debridement of diabetes-related foot ulcers. The protocol and how to get involved will be discussed.

Session 3: Improving care for people living in the community with diabetes

Wollondilly Diabetes Project: A Population Based, Integrated Approach for Diabetes Care

Dr. Rati Jani - Diabetes Dietitian Specialist, Dr. Freya MacMillan - Lecturer Interprofessional Health Sciences and Prof. David Simmons: Director, Diabetes Obesity and Metabolism Translational Research Unit, Head of Department, Endocrinology, Campbelltown Hospital, The Wollondilly Diabetes Programme.

The Wollondilly Diabetes Programme (WDP) is a novel framework bridging the clinical and community systems for integrated diabetes management. The presentation will describe the WDP-clinical arm comprising of multidisciplinary specialist clinics and case-conference components for the clinical management of diabetes, and the WDP-community arm comprising of peer support facilitator led peer support groups for the social management of diabetes.

Diabetes Care Collaborative

Daniel Shaw - Innovation Manager and Maria Jessing - Clinical Improvement Manager, South Eastern Sydney Local Health District and Central and Eastern Sydney Primary Health Network.

This presentation will describe a 15 month Breakthrough Collaborative that worked to improve the delivery of diabetes management in Primary Care through greater adherence to best practice guidelines whilst improving access to LHD based diabetes services. Twelve General Practice groups were engaged and participated in four learning sets, monthly teleconferences with face to face site visits and remote support as required. Nine out of twelve practices exceeded the collaborative goal of 70% recording of HbA1c status in people with type 2 diabetes mellitus. Other outcomes include a 30% increase in microalbuminuria testing, a 20% increase in EGFR recording, an 18% increase in cholesterol monitoring and a 300% increase in eye examinations.

The AUSDRISK’s Predictive Capacity Needs to be Refined to Determine Appropriate Scoring for Persons with Spinal Cord Injury

Wendy Jannings - Spinal Injuries CNC, Northern Sydney Home Nursing Service

Given the strong association between spinal cord injury and diabetes, rather than using the AUSDRISK Tool, an annual HbA1c is recommended to assess the presence and severity of diabetes in this patient population.
<table>
<thead>
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<td>Prof. Greg Fulcher - Senior Staff Specialist RNSH, Clinical Director Chronic and Complex Medicine North Sydney LHD</td>
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<td>Prof. N Wah Cheung - Western Sydney LHD</td>
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<td>The Western Sydney Integrated Care Program is a NSW demonstration program of a new model of care for people with chronic disease, in particular type 2 diabetes, coronary artery disease and COPD. The aim is to achieve better integration of care between hospitals and primary care, and develop a whole-of-system approach. The key elements of the program and early results will be discussed.</td>
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<td><strong>The Get Healthy Service Type 2 Diabetes Prevention Program</strong></td>
<td>The Type 2 Diabetes Prevention Program was launched in 2013 as an enhancement to NSW Health’s free phone-based healthy lifestyle coaching service, Get Healthy Information and Coaching Service. This presentation will discuss eligibility, referral pathways and reported outcomes for the program as well as highlight how it can complement broader strategies to prevent the onset or delay of diabetes in high risk populations.</td>
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<td><strong>Nageen Ahmed</strong></td>
<td>Office of Preventive Health</td>
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<td><strong>Empowerment Through Culturally Appropriate Health Education in Type 2 Diabetes</strong></td>
<td>This presentation focuses on the relevance of providing culturally appropriate health education for people living with diabetes with the ultimate aim of empowering them in the control and management of their chronic and complex disease. The model discussed has been in place for the last 20 years using a holistic approach to health management in primary care.</td>
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<td><strong>Gladys Hitchen</strong></td>
<td>Diabetes Educator, Senior Clinical Dietitian Cumberland Hospital</td>
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<td><strong>Sumathy Ravi</strong></td>
<td>Western Sydney Diabetes Coordinator Western Sydney LHD</td>
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<td><strong>AusCDEP: Competency-based Online Diabetes CPD for Health Professionals.</strong></td>
<td>Online competency-based diabetes CPD for health professionals is being introduced in primary and hospital care in south west Sydney. AusCDEP, the Australian version of the Cambridge Diabetes Education Program, supports all levels of healthcare professionals demonstrate their diabetes knowledge and skills relevant to their role. A variety of diabetes specific topics will be available, amounting to 28 hours of diabetes study time.</td>
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<td><strong>Therese Fletcher</strong></td>
<td>Diabetes Research Nurse Campbelltown Hospital</td>
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| **Julie Gale**  
Diabetes CNC  
Prince of Wales Hospital | **Hospital Frequent Fliers: Commonalities Seen Between Patients Re-presenting to Hospital**  
As part of the ‘CNC Strategic Project’, which was looking at characteristics of patients frequently being re admitted to hospital, patients with diabetes were identified as being one of the groups of patients most likely to return to hospital within a short period of time. The clinical notes of 26 patients with diabetes were looked at to identify any commonalities between them so that this information may inform future service requirements and avoid patient re-admission. It was found that whilst there were many re admissions, there was also even more re-presentations to the Emergency Department and commonalities between patients were identified. |
| **Aiden Shi**  
Application Specialist  
eHealth NSW | **The Glucose Management Mpage – An ACI, eHealth, LHD collaboration in eMeds**  
With the wide spread implementation of electronic medication management (eMeds), there was an opportunity to enhance clinical decision support beyond the constraints of paper Adult Subcutaneous Insulin Paper Chart. eHealth engaged the ACI and LHD to develop a Glucose Management Review page through applying User-Centred Design (UCD) principles and an iterative approach. The Glucose Management Mpage improved the viewing ability for displaying temporal relationships between blood glucose and ketone levels with glucose-related medications, primarily insulin, in the eMeds system. |
How to get to the Kirribilli Club

Address
11 Harbourview Crescent, Lavender Bay NSW 2060

Location

Transport

Access
Kirribilli Club is wheelchair accessible, with level entry on the ground floor. Elevator access is also available from the parking garage (Basement Levels 1 and 2) to all Club floors.

City Rail
The closest train station is Milson Point.
Train timetables are available at: www.cityrail.nsw.gov.au/timetable
Transport Info Line Phone: 131 500

Parking
Kirribilli Club has 65 car spaces available, located on Basement Levels 1 and 2. The car spaces are available on a “first come, first served” basis and cannot be reserved.

The Car parking rates are as follows:
Non-members / temporary visitors $12.00 per car per day