Wollondilly Diabetes Programme (WDP):
A Population-based, Clinical and Community Systems Integrated Approach for Diabetes Care

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What about Number with/at risk of Diabetes?

- N = 46,000
- n = 2,100 Known Diabetes
- n = 15,000 overweight/obese
Wollondilly Health Alliance: Governance

Integrated Care Collaboration

Wollondilly Health Alliance

Care Process Working Group
- PROMPT-Care
- Secure Messaging
- Diabetes
- Sub-Working Groups

Health Promotion Working Group
- Dilly Wanderer
- Healthy Towns
- Wellbeing
- Diabetes
- Sub-Working Groups

SWSPHN, SWSLHD, Wollondilly Shire Council,
Wollondilly Diabetes Programme

Prevention

Primary care support

Community support: with/at-risk of diabetes

Clinical support: primary & secondary care

Integration Support

WDP

Peer support

Clinical management
Integration support

- WHA joint oversight
- Clinician Reference Group
  - 2 monthly meetings-education/joint development
- Agreed/available Referral pathways (HealthPathways)
- Standardised, shared online HCP diabetes education platform (AusCDEP)*
- Joint information management (Swishcare)
Diabetes Passport

Patient Passport

Surname: Brown
First Name: Julian
NHS Number: 987 654 3210
Surgery Name: Litcham
Gender: Male
Surgery Ref: 00001
Status: Priority

www.switchacre.org
Access: patient controlled

Patient provides card to HCP

HCP accesses data: password, authenticator, passport number

Links to cloud (Swishcare)-di-identified data

Cloud data on WSU secured server

Data entered by patient, HCP, imported from databases with patient consent

Diabetes Passport: N= 4000 for DM/PreDM

One stop platform: provides integrated, multi-disciplinary overview about the patients diabetes care
WDP Primary care support

Case Conferencing:
- Patient not present
- Quick (15-20 mins/case)
- For patients at high risk of complications
  - Eg HbA1c 9+%, nephropathy, trigs 10+ mm/l
- Joint discussions/enhancement of care: Endo/GP+1
- Incorporates HCP Education for other patients
- Facilitates articulation with allied health/other services
- Allows volumes

Medicare funded

Commenced at the Picton medical centre
WDP-Peer support

- **Support in managing day to day living:** Sharing experiences on diabetes (diet, physical activity)

- **Social and emotional support:** Empathetic listening, motivation

- **Linkage to clinical care:** Bridging the gap between primary care and community residents (peers)

- **Provided by:** Trained Peer Support Facilitator, Facilitator, not an educator/clinician

Simmons et al., 2015; Fisher et al., 2012
PSF facilitated Peer Support Group Sessions

• **Discussion topics**: Combination of 12 healthy messages and/or 10 diabetes discussion topics

• **Duration**: 1/month for a minimum of 1 hour

• First 1-2 support sessions attended by WDP (sustainability)

• **Follow-up** support to PSF: WDP calls fortnightly; face to face meeting with PSFs 1/month for one hour
Announcing
the much awaited
launch of Wollondilly Community Pantry...

$24 WORTH OF FOOD FROM A MAJOR GROCERY STORE

Affordable groceries, household items, fresh fruit and vegetables, milk and bread

Starting November 10, 2015 • Every Tuesday 10.30am to 12.30pm
Community Links Wollondilly, Tahmoor Community Centre
6 Harper Close, Tahmoor NSW 2573
For further information on this service, contact Paula on

Free Morning Tea

Heart Foundation Walking

Tahmoor Community Garden
WDP clinical-addressing local access issues

- **Endocrinologist/Educator/Dietitian-Multidisciplinary clinics**
- See patients 1-2 times, give advice to GPs for ongoing care
- Type 2 diabetes

- **Allied health clinics (individual assessments/consultations)**
  - Podiatrist
  - Dietitian
  - Diabetes educator

- **Group sessions-Educator/Dietitian**

Medicare billed where possible/self referrals accepted

Commenced in Tahmoor: Wollondilly Community Health Centre
Recruitment approaches

1. General practices *(30 seconds video)*
2. Referral-GP case-conference
3. Flyer distribution
4. Talks at community groups
5. Media *(Newspaper, Radio)*
6. Online *(WDP Facebook page)*
7. Word of mouth
8. Door to door survey
9. WDP road show *(starting soon!)*
Preliminary outcomes

**WDP clinical services**

- Multidisciplinary clinics bi-weekly
- Case conferences weekly
- 7/9 GP practices collaborated with GP (90% referral: Picton/Tahmoor)
- *patients seen per discipline:*
  - Endo (case-conference) 36
  - Educator 14
  - Dietitian 22
  - Podiatrist 17
  - Groups 10

  Male 31 : Female 28

**WDP peer support**

- Ongoing recruitment via all 9 approaches (e.g. +2000 flyers distributed across Wollondilly)
  - PSF: N= 10
    (Type 2= 8, Type 1= 2)
  - Peer: N= 4
    (Type 2: 3, at-risk: 1)
  - Male 7 : Female 7
Clinical-community systems integrated approach (Dietz et al., 2017)

Conclusion

Individual engagement and empowerment
Optimising individual’s diabetes care or diabetes prevention by offering both clinical and community support

Clinical management system
Health professionals (e.g. GP, dietitian, podiatrist, etc) providing diabetes care

Community support system
Community services, organisations promoting diabetes social support and health promotion

Integration of clinical and community systems
Thank you