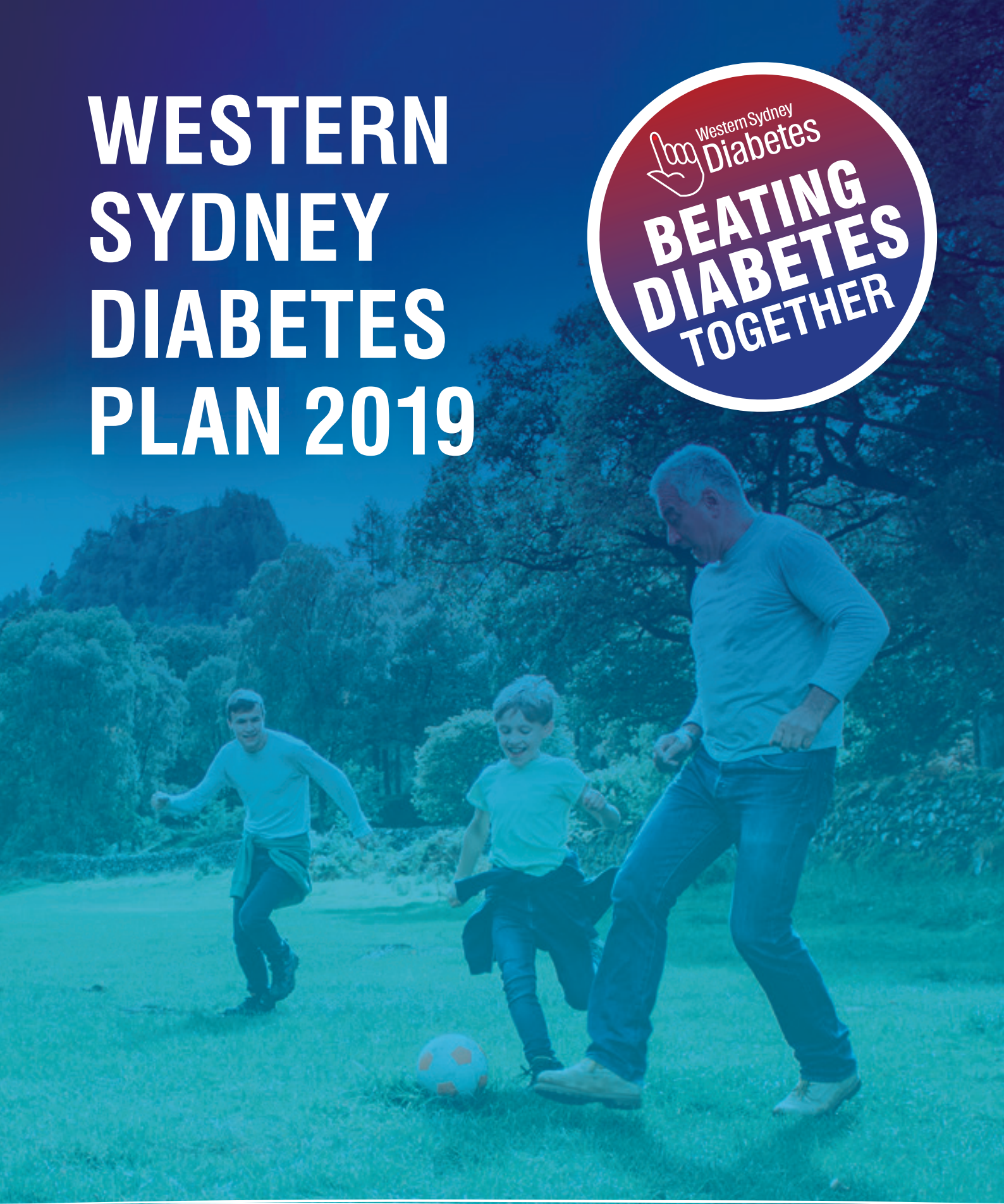


WESTERN SYDNEY DIABETES PLAN 2019



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PURPOSE OF THIS DOCUMENT

Western Sydney Diabetes (WSD) is led by Western Sydney Local Health District (WSLHD), Western Sydney Primary Health Network (WSPHN), Diabetes NSW and ACT, and PricewaterhouseCoopers (PwC).

We have an Alliance of over 100 active member organisations committed to helping 'beat diabetes together' in western Sydney. Each January, WSD undertakes annual planning with our core team, lead partners and alliance members to set our direction and focus in addressing key indicators under the WSD Framework for Action.

The plan is a practical yet ambitious commitment and relies on resources available at the time. This important work cannot be done however, without the ongoing and growing commitment of our community leaders and partners.

In December each year, we undertake a Year-in-Review to audit and document our progress and achievements in meeting our strategic objectives. This document starts again our annual planning and reporting cycle.





EXECUTIVE SUMMARY

“The goal of Western Sydney Diabetes is to increase the proportion of the healthy population and reduce the size of the at-risk population.”

The WSD 2018 Year-in-Review (YIR) sets the stage for the 2019 calendar year. We have not yet reached the tipping point in ‘taking the heat out of our hotspot’. In fact we have documented that the burden of diabetes is larger than has been traditionally reported. Opportunistic testing to detect diabetes and pre-diabetes in Emergency Departments and in General Practices continues to affirm that 17% of adults have diabetes and 30% have pre-diabetes. In Blacktown and Mt Druitt hospitals (BMDH) 22% of admitted patients have diabetes and this is steadily growing at 1% each year.

It is not all bad news however, the 2018 YIR demonstrated how with existing resources, 23 of our interventions in the WSD Framework for Action, are underway. It is also demonstrating the power of synergism among these interventions across the broad spectrum of our program. The WSD initiative

was presented and reviewed by the WSLHD Board in December 2018 and a commitment was made by the Board chair and WSLHD Chief Executive, to support and incrementally expand the local investment in WSD. There was also a commitment to work together and find a larger local, State and Commonwealth investment by both public and private sectors to help bring this effort to scale to help reverse and slow the growing diabetes epidemic in our District.

Our strategic Framework for Action is adapted in this 2019 plan to include a more focused place-based mobilisation component. With such limited resources we are not in a position to roll out interventions evenly across the 1 million people in our district. Last year we adopted a concentrated approach in Toongabbie and Mt Druitt, with some ongoing and enhanced efforts in Blacktown CBD and Parramatta. Each of these place-based efforts take on a different character and are tailored to suit the needs of the particular local community in which they operate. We were pleasantly surprised at the local interest and responsiveness of local leaders and consumers to the diabetes challenge and willingness to form a grassroots response and own and support this effort. We will continue to foster this approach this year.

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Neighbouring jurisdictions have also expressed interest in adopting all or some elements of our WSD Framework. In 2019, we will respond to this growing interest from South West Sydney Local Health District and Penrith and Blue Mountains Local Health District, who have a similar social and economic environment and are part of a continuous geographic western Sydney diabetes hotspot. There have been several overtures to consider expanding the WSD to a Greater WSD and this will be explored further this year. This will however require an enhanced investment by State and or Commonwealth governments, so we need to ensure the preservation of the unique collaborative partnership aspects of WSD.

A central and unique aspect of WSD's program revolves around building the capacity of General Practice to better manage diabetes. In 2018, we assisted both Mudgee and Goulburn through 'demonstration joint Specialist- GP case conferencing'. It was clear there was a great need and strong desire by GPs in these towns for this support. In 2019 we will implement a phased adoption of two to three towns using visits and tele-health, not to manage patients with diabetes, but to build the local capacity of GP practices in a sustainable way.

Other jurisdictions including South Brisbane, Australian Capital Territory, Northern Melbourne and Western Australia have reached out to engage and learn more of the WSD Framework. We will continue to visit and communicate with teams in these jurisdictions to collaborate by disseminating our learnings and learning new approaches from them. Resources permitting, we also plan to implement a Joint Specialist, Community Health and General Practice diabetes outpatient service in the Mount Druitt Community Health Centre. This is a proven successful ongoing intervention in South Brisbane. South West Sydney and Hunter New England LHD run successful GP Master Classes and we would like to combine that with our Case Conferencing and Practice Nurse training this year.

Data for Decision making has been a key element of WSD, but this year, with the benefit of a grant from the Australian Digital Health Agency (ADHA) to PwC, we

are committed to building an enhanced WSD Diabetes dashboard. When operational, this will continuously document trends in burden and cost of diabetes in hospital and monitor progress in all our interventions. It will enhance our ability to target specific intervention to patients in hospital and areas of management that could be improved.

'A central and unique aspect of WSD's program revolves around building the capacity of General Practice to better manage diabetes.'

Rolling out and scaling up the WSD patient self-management App is now underway and will occupy much attention by our core team and WSPHN partners in 2019. When we reach a critical scale of adoption, we will undergo a randomised control study to examine the benefits of this approach. Many aspects of this remain challenging but we now see real progress in overcoming the challenges and potential to bring this to scale.

2019 is very much a political year with looming State and Federal elections. Health and hospitals certainly seems to be a key political topic, but whether the diabetes problem (the largest burden of disease in Australia and the most expensive element of health care in Western Sydney) features in the election debate is as yet uncertain. Given the constraints that come with elections, where it is feasible, we will continue to enhance public awareness of the problem and solutions. It has taken 20 years for Australians to gain on average 4 kgs of weight and it will take more than one election cycle to reverse this trend. That is why when seeking additional resources we always ask for more permanent and sustainable commitments.

Please read and engage with this plan and if you find there are elements that do not adequately reflect your work or commitment, please let us know and we can adapt our focus for 2019. Furthermore please help us find the much needed resources to bring this program to scale.



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FRAMEWORK FOR ACTION

The WSD Framework for Action underpins the WSD 2019 Strategic Plan and will guide all work by the core team and Alliance partners in 2019. The Framework comprises two major sections including Primary Prevention and Secondary Prevention and Management, with key indicators under each. The following section of this document outlines key actions to be undertaken this year to progress these goals.

FRAMEWORK FOR ACTION



AN ALLIANCE OF 113 PARTNERS • ALL TIERS AND SECTORS OF GOVT • PRIVATE SECTOR • NGO • UNI & EDU

PRIMARY PREVENTION



IMPROVING FOOD CONSUMPTION
INCREASING PHYSICAL ACTIVITY
BUILDING HEALTHY ENVIRONMENT



GOVERNMENT LEADING THE WAY

SECONDARY PREVENTION AND MANAGEMENT



HbA1c TESTING
LIFESTYLE COACHING
JOINT CASE CONFERRING
HEALTH PATHWAYS
GP SUPPORT LINE
WSD APP
COMMUNITY PHARMACY
PRACTICE NURSE TRAINING
SHARED HEALTH SUMMARY



SAVE A LEG
COMMUNITY EYE PROGRAM
RAPID ACCESS CLINIC
CGM FOR DIAGNOSTICS
INTEGRATED CARE
HEALTH CARE HOME
IN-HOSPITAL CARE
EDUCATION CENTRES
BARIATRIC OBESITY CLINIC



PLACE-BASED MOBILISATION



PUBLIC AWARENESS



DATA FOR DECISION MAKING



RESEARCH AND PUBLICATIONS

PRIMARY PREVENTION

The focus during 2018 was the creation of a whole of community approach for the prevention of diabetes. The goal was to grow membership of the Diabetes Prevention Alliance and then create opportunities for our partners, either individually or in partnership, to implement changes to the environment of western Sydney. This will remain the prime focus during 2019, however new opportunities arising from the growth achieved during 2018, will enable a more focused approach in specific areas of prevention.

WSD ALLIANCE

The Alliance is now a network of 113 member organisation and has reached a size and diversity of members that will make it possible to establish groups within the Alliance to concentrate on specific areas of interest and expertise.

The key objectives for the Alliance will be to:

- Grow membership to 125 active organisations during 2019, particularly through an increase in the number of organisations from the corporate sector, councils (covering Greater Western Sydney), SWSLHD, Nepean/Blue Mountains LHD, NGOs, health insurers and weight loss organisations.

- Conduct two Alliance meetings during May and October. These meetings will aim to include all member organisations from each participating sector with the aim of providing updates and networking opportunities. The May meeting will include a showcase of member activities with the aim of creating collaborative and funding opportunities.
- Complete, test and launch the Information Hub by May 2019.
- Obtain notification of upcoming grant and tender opportunities which can be distributed to the Alliance members via the Information Hub.
- As opportunities arise, establish and conduct working groups to progress selected programs or interventions relating to Food and Physical Activity. These working groups may be focused on such activities as RunWest, WS Parklands, Stephanie Alexander Kitchen Gardens, Jamie's Ministry of Food and the establishment of community gardens in social housing districts.

CORPORATE RELATIONSHIPS

The work of WSD spans both the prevention and treatment of diabetes. This means that our efforts align closely with the goals of many corporate entities. It will be a goal during 2019, to develop stronger relationships with those organisations with whom we currently work, such as pharmaceutical companies, along with reaching out to additional organisations where a mutually beneficial relationship may be possible. Opportunities include sponsorship for our own or our partners' work, along with the provision of advice, specialised expertise or the provision of employee's labour for our various interventions. Approaches will be made through our relationships with the Sydney Business Chamber, local clubs, pharmaceutical companies, medical insurance companies and the Western Sydney Dialogue.

IMPROVING FOOD CONSUMPTION



The goal of WSD remains to improve access to fresh food and to increase the knowledge of our residents on what constitutes healthy food, along with the provision of skills in the preparation of nutritious meals for themselves and their families.

Support interventions:

- Source and promote opportunities for the setting up and financing of cooking classes for CALD groups and those at social or financial disadvantage. Partners: Jamie's Ministry of Health Australia, OzHarvest, Get Kids Cooking, TAFE.
- Investigate opportunities for the setting up of community kitchen gardens within Community Housing estates. Partners: ICH, FACS, Councils, various Alliance partners.
- Introduce a hub of Stephanie Alexander Kitchen Gardens in Blacktown schools. Partners: SAKGF, DET, multiple Alliance partners.
- Commence community education classes for young mothers, post natal GDM and CALD groups. Partners: DNSW&ACT, Multicultural Health.

INCREASING PHYSICAL ACTIVITY



The promotion of physical activity will continue through the identification and promotion of facilities and the provision of opportunities for the community to undertake a form of physical activity of their choice.

In addition, specific efforts will be directed to the establishment of working groups to achieve the following:

- Increase the number of GP walking groups from 22 to 30 GP practices. Partners: WSPHN, Heart Foundation, local councils.
- The promotion of facilities and increase physical activity within the WS Parklands and the usage of the Great West Walk. Partners: WSPT, WSROC, Alliance members, Population Health, National Parks.

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- Support community events aimed at increasing activity of Western Sydney residents such as RunWest and Lions Club community forums.

BUILDING A HEALTHY ENVIRONMENT



WSD can have an influence on urban planning through continuing to include relevant organisations in the work of the Alliance and through ensuring participation in appropriate events relating to urban heat, urban upgrades, planning and new developments. Partners: WSROC, Councils, GP groups, Sydney Business Chamber, Western Sydney Dialogue, Government Architect, Greater Sydney Commission.

GOVERNMENT LEADING THE WAY



A Steering Committee for WSLHD Healthy Food and Drink in

Health Facilities has been established and is chaired by the General Manager, Westmead and Auburn Hospitals. This program supports the implementation of the NSW Health Framework for Healthy Food and Drinks in all health facilities.

Population Health, with support from WSD, are successfully driving this to make WSLHD an exemplar for adoption and now local food vendors are firmly on board. Work is underway in 2019 to ensure all catered functions in WSLHD also put these messages into practice. We will also explore how this approach could be spread to other local or State government entities in our district.

SECONDARY PREVENTION & MANAGEMENT

In 2019, the WSD team plans to refine and expand on the interventions for Secondary Prevention and Management.

HBA1C TESTING

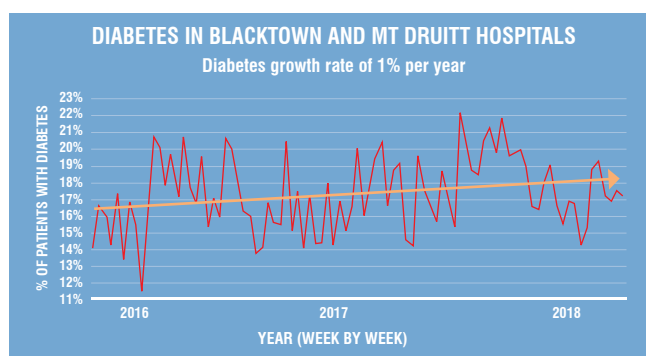


Diabetes Detection and Management Strategy (DDMS)

- Routine Diabetes detection (HbA1c) in BMDH Emergency Departments will continue. In 2019: Patients who test positive for diabetes or pre-diabetes, will continue to receive a letter outlining the results, and a letter is sent to their GPs as well.
- Due to logistics, efficiencies and costs associated with sending notification letters, DDMS is currently reviewing the HbA1c result notification process in view of implementing faster and more cost effective ways to inform patients of their HbA1c test result. This includes an SMS messaging service and utilisation of GoShare HealthCare service, a customisable content distribution platform enabling sharing of health resources, tailored to patients' information needs.
- DDMS – Multicultural Health Service (MCHS) BCE program 'Diabetes awareness in your community' will be offered again, this time to the Arabic and Filipino DDMS cohort. The program will commence in late March 2019, at Mt Druitt Community Health Centre. There are 80 Arabic and 123 Filipino speaking patients with pre-diabetes (HbA1c range 5.7% ~ 6.4%) residing in and around Blacktown and Mt Druitt area. Post program evaluation will reveal feasibility of further expansion to other languages/CALD communities.
- A DDMS – WSLHD Population Health joint project is planned for July 2019, offering 'Get Healthy' Chinese coaching program to DDMS identified Chinese speaking patients. Get Healthy Information and coaching service have recruited and trained Chinese speaking coaches to deliver culturally appropriate coaching for Mandarin and

Cantonese speaking participants. WSLHD has been chosen as one of the initial sites to roll-out the new Chinese GHS program. There are 447 patients identified as either speaking Cantonese or Mandarin, 21.3% with diabetes and 43.8% with pre-diabetes (based on DDMS data from June 2016 – Feb 2019).

- A live in-hospital surveillance system (Diabetes Dashboard) for individuals admitted with diabetes, continues to undergo enhancement and will be used to better monitor and manage those with diabetes within the hospital resulting in high-quality diabetes care.
- In 2019, DDMS aims to explore means such as social media/online platform to engage with people aged between 20 – 39yrs. This age group occupies 33.3% of overall DDMS cohort, out of those 15% have HbA1c range consistent with pre-diabetes and 4% consistent with diabetes and the trend is worryingly rising.
- DDMS will continue to explore novel methods of healthcare delivery using technology in 2019 through partnership with WSPHN and other healthcare providers.



Total number of patients tested June 2016 to Jan 2018: 48,000.
 Trend calculated using least-square method, $R^2=0.1$

Promote Diabetes Detection in the community

A pilot research project in 2018 using the same hospital protocol for HbA1c was undertaken in 11 General Practices across five geographical locations in western Sydney, including Blacktown, The Hills District, Mount Druitt, Toongabbie and Westmead. This surprisingly revealed high rates in the community similar to the Blacktown and Mount Druitt hospitals testing. We will work closely with WSPHN to see how

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early detection with yearly HbA1c testing can be rolled out across the district. Initially we will focus on the practice in the placed-based areas. We need to foster GP champions to promote this work.

LIFESTYLE COACHING



Integrate Primary prevention work with Secondary Prevention to promote lifestyle options

A Healthy Living Options booklet has been prepared which outlines a variety of local lifestyle options aimed at improving the health and wellbeing of residents. Suitable for patients at risk, with diabetes or just wanting to improve their health, the activities included are either free or very inexpensive. The aim in 2019 is to expand this to provide an even wider variety of choices so that every reader can find at least one activity that they would enjoy. This booklet, which is also available online, is continually updated and added to as new options become available. It is accessible to all GPs, health professionals and distributed through the WSD patient contact.

Linking HbA1c measurements to Lifestyle modification

This year, WSD will deliver two additional community diabetes events in Blacktown and Mount Druitt. DDMS patients will be invited to these community events if they live near the event location and have been identified as having pre-diabetes or diabetes via the HbA1c testing extending to wider community and local medical practices. According to BMDH Inpatients Diabetes Dashboard data, 18% of patients are from Blacktown postcode (2148), with 31% with pre-diabetes and 18% with diabetes. 17% of patients are from Mt Druitt postcode (2770), with 29% with pre-diabetes and 20% with diabetes.

'A Healthy Living Options booklet has been prepared which outlines a variety of local lifestyle options aimed at improving the health and wellbeing of residents.'

JOINT CASE CONFERRING



Enhance Joint Specialist Case Conferencing (JSCC)

We aim to continue the collaboration between WSPHN and WSD to build the capacity of primary care to manage diabetes, by assisting GPs and practice nurses to interpret and apply the dynamically changing diabetes management guidelines.

- Continued engagement with the Westmead Hospital team, who now deliver regular JSCC under the auspices of the Western Sydney Integrated Chronic Care Program, and whose capacity will grow in 2019 with the addition of a 0.5 FTE staff specialist supported by WSD.
- Although JSCC will be delivered across the WSLHD we also plan to consolidate our Place-Based approach, so again the focus in 2019 will be in Blacktown, Mount Druitt and Toongabbie, for the Blacktown team and focused on engaging new GP practices.
- Aim to identify some GP champions to provide guidance as the service expands and evolves.
- Aim for 3-4 JSCC per week, with a minimum of 4 patients at each session.
- Target new GP practices and GPs where their patients are being referred to and discharged from Rapid Access and Stabilisation at Westmead Hospital and the Complex Type 2, High Risk Foot Service clinics at Blacktown Hospital.
- Collate the main topics of learning for the GP, and use this information to guide future education programs.
- Continue to support and engage with the Western Sydney Aboriginal Health Service.
- Design a new evaluation form for GP and Practice Nurse feedback.
- Continue to provide GPs with the Category 2 RACGP CPD points for each hour of JSCC.
- Develop an annual Diabetes Master-class with Category 1 RACGP CPD points, linking the practical learnings from JSCC to the Master-class.

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Outreach visits Joint Specialist Case Conferencing

In 2018 the provision of an outreach service with JSCC was initiated to rural areas of NSW. Strengthening this work in the coming year will be a priority to support regional and rural diabetes services.

- Aim to hold at least 2-3 JSCC visits to regional towns.
- Complement the JSCC visit by additional education for GPs and Practice Nurses to build capacity of their diabetes knowledge.
- Develop and test the use of Tele-health to provide an ongoing capacity building service to rural GPs.

Mental Health Engagement

With the appointment of Dr Ram Ganapathy, staff specialist in Psychiatry and Medical Superintendent and clinical director of Blacktown and Mount Drutt Mental Health Services, this program has been re-ignited. There is commitment and enthusiasm to strengthen the collaboration between the two teams to build their capacity to manage diabetes and metabolic health for patients through the following:

- Continue monthly JSCC with the Mental Health team, where at least four patients are reviewed per session.
- Encourage participation of the nursing staff from the ward or mental health care worker from the community.
- To facilitate upskilling, encourage nursing staff in the mental health unit to complete the online HETI Diabetes training part 1 and 2 and consider completing the NADC on-line education program.
- 6 monthly Diabetes Management Update Session at the Mental health Unit
- Collaborative research project between WSD and the Mental Health team to evaluate the outcome of the intervention (JSCC) compared with a similar service where JSCC is not available.



HEALTH PATHWAYS



Promote HealthPathways

HealthPathways is an invaluable resource directed toward General Practice to help provide succinct information and resources. WSD provides feedback on the information to WSPHN to try and keep the information current.

Medications and treatment guidelines related to diabetes are changing rapidly and WSD clinical team will review and update the diabetes pathways during 2019.



GP SUPPORT LINE



The GP support line acts as an easy contact for GPs to discuss management of diabetes for their patients and escalate hospital reviews via the rapid access service. This support is appreciated by GPs and will be continued. JSCC is also promoted during these calls to allow further upskilling in the general practice.

WSD APP



Given the growing burden of diabetes in western Sydney both on the hospital and community health systems, the WSD App “Diabetes Together” has been created and is currently undergoing development to promote self-management of diabetes, but also connecting GPs to the patients through the technology, so as to create shared goals to achieve target metabolic outcomes.

In 2019, we aim to continue to collaborate and build the app with our partner Longevum, along with Wentwest, GoShare Health. Goals include:

- Continue to build clinical algorithms for specific patient self-management into the app to make it a smart app, responsive to individual needs. Delivery of messages based on blood sugar levels as well as videos and fact sheets as educational resources.
- Produce a total of at least 75 diabetes education videos with GoShare, for integration into the app in the initial phase.
- Integrate a GP information exchange with the app on information such as BMI, HbA1c, eGFR, Medications etc., via the HealthLink secure messaging architecture.
- Evaluate at every stage of the development process, which will include:
 - Working initially with the seven General Practices who have signed up to be part of the app trial prior to June 2019, and subsequently extend to other practices.
 - An iterative design methodology that allows quick changes to be made to the app based on patient and GP feedback.
 - Regular design workshops to look at the efficacy of the application and how it can be improved, with input from consumers and experts involved in the development.
 - More formal evaluation around June 2019, after the initial iterative design phase ends, with two main arms. Firstly, WSD will create an app cohort of patients who will be enrolled

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long-term in a prospective study that will look at the experiences of consumers with diabetes in western Sydney. There will also be a formal evaluation that will take the form of a randomised controlled trial of the application looking at benefit to consumers and providers.

COMMUNITY PHARMACY



The pharmacy working group was established in 2017. The group includes the Pharmaceutical Society of Australia, Pharmacy Guild of Australia, DNSW & ACT, WSPHN and WSD.

The group will meet twice in 2019 to continue the community pharmacy engagement in western Sydney through promotion of WSD events on PSA e-newsletters and bulletins.

PRACTICE NURSE TRAINING



The General Practice (GP) is at the core of diabetes management in western Sydney and this not only includes the GP but the Practice Nurse and also community Allied Health providers. These need to be supported as a team. Goals for Practice Nurse training in 2019 include:

- Broaden the education offered to practice nurses in JSCC at GP practices with core education activities including foot checks, injection technique, hypoglycaemia management and nurse lead topics.
- Seek sponsorship for the National Association Diabetes Centers (NADC) National Diabetes Care Course for at least 30 Practice Nurses.
- Include Practice Nurses into a GP master-class education day for the second half of the year with an emphasis on interactive activities.
- Seek Australian Practice Nurse Association endorsement for the master-class education day.
- Pursue other opportunities to incorporate placed-based activities into the Practice Nurse training.



SHARED CARE PLANNING AND LINKEDEHR



LinkedEHR is care planning tool specifically designed to provide an electronic shared-care plan. The Care Plan, created by the General Practitioner

together with their patient, records goals, targets and allows for referrals between members of the patient's care team. LinkedEHR supports the management of patients with chronic conditions, enabling health professionals support the coordination and delivery of care, ensuring patients will receive the right level of care required. LinkedEHR is the care planning tool utilised in western Sydney in both the Health Care Homes and Integrated Care. WSPHN continues to grow its uptake in western Sydney.

SAVE A LEG



The High Risk Foot Service (HRFS) is a small service at Blacktown Hospital that is undergoing expansion. This year the focus will be:

- Recruitment of a second 1.0 podiatrist (Level 3).
- Re-grading of current podiatrist to a level 4.
- Start of a second vascular surgeon so that there is a vascular surgeon and fellow present weekly at the HRFS clinic.
- Work with Leading Better Value Care Program (LBVC) to improve and meet best standard practices.
- Better streamline the weekly multi-disciplinary HRFS.

- Implement data collection to allow better capturing of clinical activity and to allow research opportunities.
- Continue to connect to the Community 'Save a Leg' program.

COMMUNITY EYE PROGRAM



WSD will continue to work with Westmead Ophthalmology team led by Prof Andrew White and community optometrist Joe Nazarian, to promote community eye screening through their secondary referral centre in Blacktown. The aim is to improve waiting times and to prioritise diabetic retinopathy and glaucoma. We aim to hold an Eye Forum this year targeted at community GPs to promote this program.

Outpatient Eye screening

Together with an ophthalmology research group from Westmead, a retinal screening project was started at Blacktown and Westmead diabetes clinics to opportunistically detect and highlight diabetic retinopathy. This will continue and be completed in 2019. WSD will evaluate opportunities to incorporate eye screening in the diabetes outpatient clinics.

RAPID ACCESS CLINIC



Redesign Diabetes Clinics Blacktown Hospital

In 2018, a redesign project was undertaken to improve patient and staff experience of the growing diabetes clinics at Blacktown hospital. This year, we will implement key recommendations identified, including implementation of a streamlined triage and referral process, pre-clinic workup by the Community Advanced Trainee and Resident Medical Officer for some of the diabetes clinics to reduce clinician time wastage during clinics, and improve booking schedules to reduce patient waiting times.

New joint Specialist General Practice Community Diabetes Clinic at Mt Druitt Community Health Centre

Blacktown Mt Druitt Hospitals (BMDH) Endocrine and Diabetes Department and Western Sydney Diabetes

(WSD) and Clinical Operations (CO) in Integrated Community Health (ICH) Directorate, have identified the need for and benefit of, establishing this new clinic service in Mt Druitt Community Health Centre. Four GPs would be hired by WSLHD to support this sessional work, held every Thursday morning. A business plan is being developed.

Mt Druitt is our hottest 'hotspot' of diabetes and recent HbA1c testing by General Practices showed diabetes rates as high as 35% of people tested.

This would bring together a Hospital Outpatient Specialist Clinic, General Practice (GP) capacity building, and integration with Clinical Operations community diabetes services. It would provide the same quality of diabetes management as hospital based clinics but with quadruple the capacity, bring the service closer to where patients with the greatest need live.

Audits of new medications, Blacktown Hospital

Three new injectable medications were introduced onto PBS in 2018. The clinical team will continue to collect data on these and further new medications that may be introduced this year to monitor their efficacy and patient experiences.

CGM FOR DIAGNOSTICS



The complex Type 2 diabetes outpatient clinic will continue to use Continuous Glucose Monitoring (CGM) as an adjunct tool to assist with assessment and guide management decisions. These help towards better stabilising patients' glycaemic control and discharging back to GPs, to facilitate space in the highly demanding clinics to see new patients promptly.

- The new *Freestyle Libre* Flash glucose monitoring introduced in 2019, will help reduce the clinical time taken for insertion, removal and interpretation of CGMs.
- A separate diabetes educator CGM clinic may be trialed this year.
- A business case will be undertaken by a Health Management Intern, Integrated & Community Health.

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INTEGRATED CARE



Build capacity to better-manage diabetes in Integrated and Community Health (I&CH)

The Integrated and Community Health Directorate has about 600 people working at the interface between acute hospital services and the community. Many of the frontline staff are dealing with patients with diabetes so it is important to ensure they have the knowledge and tools to do this and better connect with hospital and community services. We have a Diabetes Educator whose role it is to co-ordinate this capacity building. Plans for 2019 include:

- Build the capacity of the WSD diabetes educator's capacity, through the completion of a Clinical Teacher Training Program conducted by the University of Sydney in partnership with the Westmead Precinct Education Hub.
- Collaborate with lead staff of I&CH to establish education needs and priorities of I&CH staff for 2019.
- Promote the NADC National Diabetes Care Course for key I&CH staff.
- Offer Care Facilitators the opportunity to participate in JSCC at GP practices.
- Offer at least two small group education sessions to I&CH staff at various sites across the District.
- Invite I&CH staff to participate in the GP/Nursing Master-class education day in the second half of the year which will have an emphasis on interactive activities.
- Seek opportunities to insert diabetes education into other I&CH events such as CACC forums.

Health2Sync and GoShare Health

The WSD clinical team continue to trial new models of care delivery in the complex type 2 diabetes clinics including the use of mHealth options such as the Health2sync App for insulin stabilisation. The trial using Health2sync app is currently being written up for publication to a peer review journal in 2019. Moving forward, as the WSD App matures it will be

used for insulin stabilisation function to allow it to be used for the diabetes outpatients' clinics. The team also intend to better utilise GoShare Health which can deliver individualised information topics delivered as a one-off or weekly over a period of time to facilitate patient education. GoShare Health is one of the main platforms used to deliver educational resources in the WSD App as well.

HEALTH CARE HOMES



Western Sydney PHN is one of 10 PHNs nationally trialling Health Care Homes. WSPHN was selected as a fast start site and launched the trial in October 2017 with 11 practices and the remaining 11 starting in December 2017. Initially a two-year trial, it has now been extended a further two years, to June 2021.

A Health Care Home is a general practice that further commits to a systematic approach to chronic disease management in primary care. This approach supports accountability for ongoing high-quality patient care. It uses an evidence-based, coordinated, multi-disciplinary model of care that aims to improve efficiencies and promote innovation in primary care services.

In western Sydney, we have worked to align Health Care Homes and the Integrated Care Program. WSPHN and WSLHD have worked together to align the principle of The Health Care Homes. There are multiple enablers supporting Health Care Homes and Integrated Care. Most Health Care Home sites are actively engaged with the many interventions offered by WSD, such as JSCC.

IN-HOSPITAL CARE



Build capacity in hospital (Cardio/Gastro/Surgery)

A fully integrated diabetes service includes enhancing in-patient management of diabetes and better-linking that to the management in the community. The Ministry of Health and the Agency for Clinical Innovation (ACI), have been working with Local Health Districts to roll out a Leading Better Value Care (LBVC) initiative related to



in-hospital management of Diabetes. WSLHD have been an exemplar in this program. Some additional components in 2019 include:

- Development of a live in-hospital surveillance system, Diabetes Dashboard to build the capacity of BMDH inpatient services to target and manage the burden of diabetes.
- Audit and then build the capacity of Specialty Services to better manage their patients with diabetes including Mental Health, Cardiology, Respiratory, Gastroenterology and General Surgery.
- Hold a Respiratory and Diabetes forum this year.

EDUCATION CENTRES



The diabetes centres at Blacktown and Mt Druitt will continue to provide education to people with diabetes in individual or group sessions, using the Health Care Interpreter Service as required. This occurs for patients who are in hospital or as outpatients.

The insulin pump education service will continue to develop for people with T1DM.

Diabetes nurse educators and dietitians will attend the outpatient medical diabetes clinics to provide a multidisciplinary service for patients. Assessment of diabetes distress in people with diabetes attending the diabetes clinics will be trialed at the Mt Druitt campus.

Clinical staff will continue to develop knowledge skills with a goal of all staff achieving credentialing with the Australian Diabetes Educators’ Association. Support and education of ward nurses in the best management of diabetes in the hospital will continue to be a priority.

BARIATRIC OBESITY CLINIC



Obesity/Metabolic Services

Obesity and diabetes go hand-in-hand. Driving the exponential growth and cost of diabetes is the rising rates of overweight and obesity, which affects nearly two in three people in western Sydney.

The Metabolic & Weight Loss Program is nearing its second year birthday. We had a busy year in 2018 seeing close to 140 new patients and have operated on 34 patients, with many of them coming off medications and reclaiming their lives. We have

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streamlined the referral, triage and education group sessions. Patients are finding the group sessions to be particularly valuable as they share stories, offer support and setup a non-judgemental system of accountability.

We have over 400 patients on the waitlist and are working hard to optimise patient entry and reduce waiting times. To meet our service needs, we are in the process of recruiting a second dietitian, physiotherapist and psychologist, with plans for a full-time nurse, second psychologist and a clinic nurse to join the program in 2019. Success in 2019 rides on the ability to attain these staff.

Over 1/3 of the metabolic patients have type 2 diabetes and they will be managed intensively in the multi-specialty diabetes metabolic clinic, a joint venture with WSD, that will see that intensive lifestyle, pharmacotherapy and services – all the way from bariatric surgery to community involvement and discharge planning – are part of the patient journey.

We will initiated a new service enhancement with Get Healthy, which will provide tailored phone coaching to our patients in the metabolic program. The 40 patient trial is set to commence June 2019.

Our second Obesity Forum is planned for May 21 2019, with a long line up of great topics and speakers.

Our research platform (Metabolic Inflammation Microbiome in Obesity) is taking off with data collection beginning this year. We endeavor to understand how obesity affects individuals and the changes that occur following weight loss. To this end, we have applied for a clinical trial using very low calorie diets and weight loss-promoting diabetes medications to see if significant weight loss, and the allusive goal of diabetes remission, can be achieved in people with diabetes diagnosed in the last few years.

PLACE-BASED MOBILISATION



The 'Place-based' approach will be building on the progress made over the past two years. WSD Core team are taking a step back to encourage this,

but also leaving the primary ownership with the local engaged leaders. Key components that are included in 2019 work will depend on local engagement and decisions made by the local teams. We have been surprised at the depth of local engagement and these groups tend to do more than we might expect.

Each place is different, but this is what the potential could look like in 2019:

Toongabbie

- Toongabbie Community Diabetes Prevention Group, consisting of local GPs, pharmacists, residents and business owners will come up with an independent plan for 2019. The group's focus is organising events and activities designed to raise public awareness of diabetes and actions in and around Toongabbie area.
- Expand GP engagement to complement and enhance the newly formed Toongabbie Community Diabetes Prevention Group.
- WSD will continue to seek engagement with local schools to promote healthy lifestyle in the school community.
- Bridgeview Medical Practice is a testing site for Diabetes Together App.

Blacktown

- Blacktown Community Diabetes forum is planned in 2019 in partnership with Blacktown City Council at Bowman Hall. It will bring together local residents, DDMS patients, GPs and Pharmacists to create a platform for education and dialogue around diabetes and healthy lifestyle.
- In 2019, WSD will continue to strengthen engagement with local GPs in partnership with WSPHN.
- WSD will explore feasibility of live streaming the Community Diabetes forum to coincide with the National Diabetes Week in July 2019 inviting DDMS cohort (with pre-diabetes and diabetes) aged between 20 – 39yrs via WSLHD Facebook page. Careful planning, support and guidance from WSLHD communications department as well as support from Alliance members will be vital.



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- Stephanie Alexander Kitchen Garden at Blacktown West Public School has been launched in February 2019, and more expressions of interest will be sought from local schools to sign up to this great initiative.
- A potential project for a community garden at Prospect Housing Estate via Tenant Engagement Project in partnership with Blacktown City Council and various alliance members will be considered.
- In 2019, more GP Walking Groups will be initiated in partnership with WSPHN.
- Respiratory and Nutrition forums are planned inviting local GPs, allied healthcare professionals, consumers and pharmacists and will showcase WSD partnerships with WSLHD, WSPHN, Blacktown City Council and Diabetes NSW/ACT.

Mt Druiitt

- Mt Druiitt Community Diabetes forum is also planned for 14 November 2019. (to coincide with the World Diabetes Day).
- WSD will consider replicating live streaming of the event via WSLHD Facebook page inviting general public and DDMS cohort.
- In 2019, even greater effort will be placed on GP and community leaders' engagement.
- Expansion of GP Walking Groups in partnership with WSPHN.
- Plans for the Mt Druiitt Community Diabetes Clinic are in progress with continued support from the local GPs, Mt Druiitt Community Health Centre and WSPHN.
- In 2019, WSD will have a focus on Islander population through Pacific Island Mt Druiitt Action Network, Mt Druiitt Seventh Day Adventist Church and Bidwill community garden in partnership with Blacktown Community Health.

PUBLIC AWARENESS



The following actions have been identified under the WSD Framework for Action and will be used to support and promote the work of the core WSD team and Alliance members.

Regular Mobilising Public Support communication meetings will be held with the relevant communications representatives from key partner organisations, to drive the following actions this year.

Appropriate channels from the below list will be used to promote the actions:

- WSLHD The Pulse
- WSLHD Twitter, FaceBook, Instagram
- WSD website
- WSD hub portal
- Metro, local and ethnic media
- WSD Stakeholder communication channels

A schedule of media opportunities and projects is outlined in the tables below:

Status	Activity type	Description	Date
Priority	Major campaigns	National Diabetes week (with joint promotion of Blacktown community diabetes event on either 16 or 18 July. Assist with Livestreaming the event via LHD FB)	13-20 July
		World Diabetes Day (include promotion of Mt Druitt community diabetes event. Assist with Livestreaming the event via LHD FB)	14 November
		National Amputee Awareness Week	4-11 Oct
		Foot Health Month	October
		National Dental Hygiene Month	October
	Major WSD initiatives	Announce any new clinics, new models of care, new initiatives /programs	As they occur
	Stakeholder communications	Assist in promoting any partner communications	As they occur
Secondary	Media enquiries	Facilitate media enquiries and interviews as appropriate	As they occur
	Trade media	Promotion of journal articles and HCP messages in trade media	As journal articles are published.
	Social media campaign	#WSDibeatIt – proposed social media campaign aimed at promoting lifestyle changes through the stories of hope from people who have managed to beat T2D	TBC once new coms officer starts.
	WSD social media	Review WSD social media channels and determine whether they will remain or whether content will be promoted via the WSLHD channels only	Once new coms officer starts.
	WSD website revamp	Review and revamp the WSD website to update content and make it more user-friendly. Consider whether content will be aimed at Alliance members or the public as well.	Once new coms officer starts

Place-based Mobilisation

Status	Activity type	Description	Date
Priority	Events	Promotion of diabetes community forums (please see reference above for Mt Druitt and Blacktown)	As required and as they occur
	Case studies	Profile successful community events run by mobilised community leaders, on the WSD website to assist in motivating other groups	As they occur
Secondary	Community Leader handbook	A user guide to assist new diabetes community groups to get started in forming their group and running community activities.	Revisit the need once current groups are well established

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DATA FOR DECISION MAKING



Data underlies everything that WSD does, and is a key component of the broader strategic plan as it supports WSD's work across all areas of

prevention and management. In 2018 WSD set and achieved a number of important data goals and the plan for 2019 reflects a similar ambition. Our planning for 2019 has encompassed an ambition to better refine estimates of diabetes prevalence, expand our monitoring and surveillance capabilities, and continue with the already advanced research agenda into the future.

Improving Benchmark Estimates

WSD has long held a goal of providing strong estimates of weight and diabetes across WSLHD, as we have demonstrated that traditional sources often under-estimate the size of the issue. To this end, we are planning on expanding our benchmark collection in 2019 by:

- Approaching Alliance partners to identify new datasets and data sources, particularly for weight estimates.
- Working with partners at the PHN and PWC to collect and display current data on dashboards.
- Better triangulate benchmarks, including work with NSW Ministry of Health, collaborating with prevention partners, and continuation of work with GPs and hospital.
- Identify health professional benchmarks, such as the number of pharmacists needed to reach in WSLHD to have an impact.

Place-Based Focus/Sentinel Sites

Improving surveillance and monitoring of diabetes for WSLHD is a challenging task due simply to the number of people that must be surveyed to obtain accurate estimates across the region. As identified by WSD in our Data for Decision Making document, one option is to address this issue with purposely selected sentinel sites. This work was begun in the last year with WSD's place-based focus, adding data collection to a number of our activities in selected areas across WSLHD, and our planning includes expanding these place-based interventions to include sentinel site data collection.

There are multiple sources of data required to triangulate the diabetes trends in an area, but these will include: GPs, Pharmacists, Schools, Hospitals, Allied health, Private pathology, Private businesses, and other data sources.

Setting up sentinel sites will improve the monitoring and surveillance of diabetes and allow for a better idea of the trends in diabetes across WSLHD than we currently obtain.

Linking Data to Decision Making

Data is important, but in and of itself does not effect change. In 2019, we plan on adopting a more focused approach to data collection and analysis in order to ensure that all data collections are made in support of WSD aims and goals. This will involve a more intensive planning process for research investigations, and reference back to this 2019 plan in order to further WSD's goals in 2019.

A large part of linking data to decision making is presenting it effectively. One aspect of this work in 2019, is the further development of in-hospital diabetes dashboards. This work is taking place in partnership with Dr. Tien-Ming Hng, Head of Endocrinology at Blacktown/Mt Druitt Hospital and Clinical Lead for Integrated Care and David Pryce, Manager of Business Analytics Services.

Another element of this work is developing dashboards to display population analytics and diabetes interventions. This is being undertaken with key partners at PWC, generously funded by a grant from the Australian Digital Health Agency. The current projected timeline has the project being finalised in October 2019.

Ongoing Surveillance

Surveillance of WSD interventions, from prevention through to management of diabetes, is extremely important. A focus of our research and data work in 2019, is to capture all data related to our interventions and display this appropriately. This includes prevention activity with our partners such as Stephanie Alexander's Kitchen Gardens, as well as management work being undertaken in people living with diabetes such as the Joint Specialist Case

Conferencing program. The work to capture and display this data is part of the ongoing work with partners at PWC and will result in a dashboard of interventions during the year.

Data Knowledge Building

Building knowledge in the team of WSD is a crucial step in improving our data collection and better understanding the situation with regards to diabetes in our patch. At the regular research meetings that will be held once monthly, we plan to hold a research forum for diabetes and research training sessions to upskill the team in important areas for diabetes research. This will significantly improve the way in which we conduct research as well as adding value by making our data collections more robust.

RESEARCH AND PUBLICATIONS



Diabetes App Research

The Diabetes Together will form a major part of the research work in 2019, with initial enrolment happening in the first quarter of the year and the full rollout of the app scheduled between in the second half of 2019. WSDA research will primarily take the form of a randomized control trial (RCT), starting mid-year and running for 12 months. This will be used to test the efficacy of WSDA as well as the feasibility in a representative cohort. The current timeline of the app development is given elsewhere in the planning document, but the research process will be:

- January-March: development of ethics applications and study protocol.
- April-June: finalising of study protocol and plans, recruitment of GPs involved in app research.
- June-end 2019: initial enrolment into study, plan for 500-1,000 patients recruited by end 2019.

The RCT will be supplemented by a prospective cohort study that enrolls interested patients who are participating in the app intervention into a long-term study. This will allow for a number of research opportunities that will improve the app as well as providing valuable information on topics such as issues that cause patients to stop using the app and how we can prevent this from happening.

'A focus of our research and data work in 2019, is to capture all data related to our interventions and display this appropriately.'

Another important element to the app research is the PhD being completed by Gideon Meyerowitz-Katz, Research, Monitoring and Surveillance Coordinator for WSD. This is taking the form of a systematic review and meta-analysis in the first quarter of 2019, and will progress to a modelling exercise to predict app dropout and improve retention in the later parts of the year.

Building on 2018 Achievements

Planning for 2019 includes building on achievements made last year. The primary elements of this work will involve moving forward with research projects begun last year, with the aim to publish research that was begun in 2018. This includes:

- **Projects to be written-up/published**
 - Health2Sync
 - CGM
 - Bydureon
 - Cardio audit 2
 - Gastro audit
 - Psychiatry review
- **Projects to be continued/started**
 - Mental health and diabetes
 - Place-based approach paper
 - Investigate sentinel site methodology
 - Medications audit
 - Respiratory audit
 - Diabetes and steroid use
 - CALD and diabetes
 - Long-term follow-up of DDMS patients
 - Outpatients
 - Pre-diabetes/GDM
 - Other outpatient data



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