
TITLE : **DIABETES PROGRAM****DISTRIBUTION:** **ALL HEALTH SERVICES IN WESTERN AUSTRALIA**

1. Purpose

The purpose of this bulletin is to provide an overview of the Diabetes Program and reporting mechanisms associated with it.

2. Background

The Diabetes Program aims to create an informed community that practices positive diabetes prevention and control, through the provision of comprehensive, integrated diabetes services. The Program outcome is expected to be enhanced diabetes services delivered by an integrated multidisciplinary team that focuses on primary and secondary prevention and treatment levels of care in hospitals, community health and public health units, with access to tertiary support and based on best practice models.

The Program follows the rationale that well organised and coordinated health care has the ability to reduce hospital admissions, increasing the efficiency of the system and therefore improving overall health outcomes.

The Program will enhance current service delivery by addressing the Imperatives for Change outlined in the WA Diabetes Strategy (WADS):

1. Improving Information
2. Implementing best practice
3. Improving service integration
4. Expanding the workforce
5. Improving understanding
6. Improving consumer information and participation in decision making.

The Program is based on the evolving Diabetes Integrated Hub and Spoke Model of Service Delivery. This model advocates locally developed diabetes plans with the assistance of supporting regional and statewide networks (refer to Department of Health (DOH) Diabetes Program Plan for more detail).

This bulletin outlines the reporting and monitoring requirements of diabetes activity at the health service level. This information will assist in the future planning of diabetes services at local and state levels.

3. Program Management

3.1 Diabetes Clinical Advisory Group

A Clinical Advisory Group, chaired by Professor Tim Welborn will undertake an advisory and support role in the implementation and evaluation of the Diabetes Program. Executive support will be the responsibility of Corporate and Finance Division DOH.

The Diabetes Program includes primary and secondary prevention community based services and non admitted services delivered by medical, allied health and nursing medical personnel in clinics attached to hospitals.

4. Program Monitoring and Reporting

The expected activity outputs and reporting requirements for each of the service delivery areas are as follows:

4.1 Diabetes Centres at Teaching Hospitals

The Diabetes Centres at RPH, SCGH, Fremantle and PM/KE will provide clinical and professional support to primary care providers of diabetes services in the metropolitan and rural regions to which they are allocated. This will include the whole tertiary care diabetes team and make provision for 24hr telephone support, enhanced communication, upskilling/education sessions and support of the local diabetes committees within the bounds of the locally developed diabetes plans. Wherever possible the use of telehealth is encouraged.

Reporting on a monthly basis

Occasions of service to people with diabetes delivered by:

Endocrinologist
Podiatrist
Nurse
Diabetes Educator; and
Nutritionist

(refer to Technical Bulletin 19/4 - Scheduled Non-Admitted Patient Services Information Reporting)

Six Monthly Program Report

Diabetes Centres will be required to submit (bi-annual) six monthly reports outlining clinical and professional support services provided and referral rates to and from primary care providers. The use of telehealth in the provision of the support services should be identified. This brief report is to be included in the Health Service Report to Corporate and Finance Division DOH.

4.2 Hospitals

Inpatient Activity

Inpatient activity for the DRGS: K60B, K60A & K01Z, will continue to be analysed on a quarterly basis through the HMDS.

Out Patient Clinics Attached to Hospitals

Reporting on a monthly basis

Occasions of service to people with diabetes delivered by:

Podiatrist

Diabetes Educator; and

Nutritionist

Nurse

(refer to Technical Bulletin 19/4 - Scheduled Non-Admitted Patient Services Information Reporting)

4.3 Public Health

Reporting on a 6 monthly basis is to continue as per the Public Health Service Specification Schedules and Program Bulletin 35/3 - Public Health Program.

4.4 Community Health

Reporting on a 6 monthly basis is to continue as per Program Bulletin 36/3 – Community Health Program and will provide information on individual occasions of service and group consultations for:

Podiatry

Diabetes Education

Nutrition

Nursing

4.5 Regional/Health Area

Public Health/Community Health Units who are the fundholders for the diabetes program funds will be required to submit 12 monthly reports on the progress towards achieving indicators of performance for Regional Integration as described in Attachment A.

(note: Areas with an Integrated Diabetes Care Project are to report as per the current IDCP contract)

4.6 Collection

Reports to be included in the health service monthly reports and sent through to the Purchasing Division, Royal St, East Perth.

5 Program Evaluation

Enhanced integration and case finding will result in an increase in activity at the health service level. However, the effect of increasing support and access to primary care providers should result in decreasing readmissions to hospitals and a long term decrease in inpatient activity in the tertiary centres. Details of the monitoring process are outlined in the DOH Diabetes Program Plan and will be further developed by the Diabetes Clinical Advisory Group.

Attachment A

Indicators of Performance			
Indicator	Output	Timeframe	Data Source/Methodology
Responsive/ Appropriate	<ul style="list-style-type: none"> • Develop and implement client satisfaction and self management surveys regarding diabetes services/providers addressing: <ul style="list-style-type: none"> - Respect for dignity - Confidentiality - Promptness - Quality of amenities - Access to social support networks - Choice of provider • Develop and implement health service provider and agency satisfaction survey • Describe and provide evidence of quality improvements and new initiatives developed in response to identified local need • Develop resources and/or services in response to local need 	Annually	<ul style="list-style-type: none"> • Liaise with local area diabetes teams and providers to administer survey of clients accessing services • Liaise with local diabetes team for development and administration of the survey to service providers
Accessible	<ul style="list-style-type: none"> • Collate and report on the following: <ul style="list-style-type: none"> - No. and type of diabetes services provided - No. of referrals to diabetes services - No. of people accessing services - Waiting periods in accessing allied health and diabetes educator services • Identify barriers to accessing care, for example: <ul style="list-style-type: none"> - Cost barriers - Transport barriers - Cultural barriers - Structural barriers - Interpersonal barriers 	Annually	<ul style="list-style-type: none"> • Liaise with local area diabetes teams and providers to administer survey of clients accessing services • Community based software system: <ul style="list-style-type: none"> - Occasions of service
Capable	<ul style="list-style-type: none"> • Audit and describe training, mentoring and workforce development provided within the region/area to health care providers • Describe and analyse service configuration 	Annually	<ul style="list-style-type: none"> • Health professional surveys • Professional bodies/agencies • Training providers

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