

# Endocrine Health Network Stakeholders Forum 3 December 2007

## Forum Report

Prepared by Health Network Branch  
Working Together to Create a Healthy WA





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# Table of Contents

INTRODUCTION .....	5
1. HEALTH NETWORKS IN WESTERN AUSTRALIA .....	6
2. THE ENDOCRINE HEALTH NETWORK.....	7
3. SECOND ENDOCRINE HEALTH STAKEHOLDERS FORUM.....	8
3.1 Forum Aim .....	8
3.2 Forum Objectives .....	8
3.3 Format.....	8
4.0 WORKSHOP - DIABETES MODEL OF CARE KEY RECOMMENDATIONS .....	9
4.1 Activity One - Individual and Pairs .....	9
4.2 Activity Two - Table Group Discussion.....	9
5.0 WORKSHOP OUTCOMES.....	10
5.1 Activity one - Key recommendations: Expected impact, Feasibility of implementation, Priority ranking - Summary of individual and pairs responses. ....	10
5.2 Activity two - Barriers and solutions - Table summary of priority responses. .....	12
6.0 WHERE TO FROM HERE: ENDOCRINE HEALTH NETWORK AND DIABETES MODEL OF CARE .....	15
APPENDICES.....	16
Appendix 1 Forum Invitations and Attendance.....	16
Appendix 2 Discussion responses - Activity 1.....	17
Appendix 3 Discussion responses - Activity 2.....	25
CONTACT .....	39



# Index of Tables

Table 1 - Improve coordination of diabetes prevention and management services.....	13
Table 2 - Enhance community-wide and targeted promotion of healthy environment and lifestyle to prevent diabetes and increase awareness of the health impact of diabetes and its complications. ....	13
Table 3 - Improve coordination of diabetes prevention and management services.....	13
Table 5 - Form advisory groups to develop, promote and audit use of guidelines, diagnostic protocols and information packages. ....	14
Table 6 - Develop information technology systems to improve communication between GP's and other service providers: .....	14



## INTRODUCTION

On 3 December 2007 the Endocrine Health Network Executive Advisory Group (EAG) and the Health Networks Branch held the second Endocrine Health Network Stakeholder Forum.

Major objectives of the Forum included:

- Discussion and prioritisation of the key recommendations of the Diabetes Model of Care.
- Presentation of the preliminary results of the statewide Diabetes Services Audit.
- Provision of an overview of the future role and activities of the Endocrine Health Network as a component of the ongoing health reform process.
- An opportunity for Endocrine Health Network stakeholders to come together to informally discuss relevant endocrine health issues.

Information gathered through the workshop component of the Stakeholder Forum is summarised in this report and will be used by the Endocrine Health Network Executive Advisory Group in partnership with Area Health Services to inform the implementation of the Diabetes Model of Care.



## 1. HEALTH NETWORKS IN WESTERN AUSTRALIA

Health Networks are being established as part of the reform of WA Health and will cover major areas of health and illness. Health Networks are a means of providing a new collaborative focus across disciplines towards the prevention of illness and maintenance of health for all Western Australians.

By forging working relationships between a broad range of people, Health Networks will:

- Plan better policy;
- Ensure better co-ordination and integration of services; and
- Increase participation, partnerships, communication and accountability across WE Health.



## 2. THE ENDOCRINE HEALTH NETWORK

The Endocrine Health Network will drive the development and facilitate the delivery of sustainable and effective prevention programs and clinical services relating to endocrine conditions. It will also forge effective and productive partnerships between a broader range of people and organisations that will promote a coordinated approach across the continuum of care.

The Endocrine Health Network will focus on the following primary conditions:

- Type 2 diabetes;
- Type 1 diabetes;
- Gestational diabetes;
- Osteoporosis; and
- General Endocrinology



### 3. SECOND ENDOCRINE HEALTH STAKEHOLDERS FORUM

Dr David Hurley, members of the Endocrine Health Network Executive Advisory Group and the Health Networks Support Branch held a three-hour Stakeholder Forum on 3rd December 2007 at the City West Function Centre, West Perth.

The Stakeholder Forum covered the following objectives:

- Discussion and prioritisation of the key recommendations of the Diabetes Model of Care.
- Presentation of the preliminary results of the statewide Diabetes Services Audit.
- Provision of an overview of the future role and activities of the Endocrine Health Network as a component of the ongoing health reform process.
- An opportunity for Endocrine Health Network stakeholders to come together to informally discuss relevant endocrine health issues.

#### 3.1 Forum Aim

The main aim of the Forum was to bring key stakeholders together to discuss and contribute to the key recommendations of the Diabetes Model of Care.

#### 3.2 Forum Objectives

It was intended that by the completion of the Forum, participants would:

- Have discussed and prioritised the key recommendations of the Diabetes Model of Care;
- Have an opportunity to discuss and consider some of the barriers and enablers for the implementation of the key recommendations of the Diabetes Model of Care;
- Have received some preliminary results of the statewide Diabetes Services Audit; and
- Have an understanding of the ongoing role and future activities of the Endocrine Health Network

#### 3.3 Format

Dr Simon Towler, Executive Director, Health Policy and Clinical Reform, provided an opening presentation on the achievements, work in progress and future activity of Health Networks in Western Australia. This included important policy developments in smoking and health and maternal care and the development of Models of Care. Following this, Dr David Hurley provided an overview of the activity of the Endocrine Health Network including the development of the Diabetes model of Care. Ms Liz Kerrigan and Mr Rob Haig from Diabetes WA then delivered a presentation on the statewide Diabetes Services Audit.

Following the presentations, a facilitated table group workshop session was conducted. Participants were seated in seven table groups, with approximately 8 - 10 participants at each table. Members of the Endocrine Health Network Executive Advisory Group with support from officers of Health Networks Branch acted as table facilitators. Mr Lindsay France, Senior Policy Officer, Health Networks Branch, was responsible for overall room facilitation.



## 4.0 WORKSHOP - DIABETES MODEL OF CARE KEY RECOMMENDATIONS

The main purpose of the workshop component of the stakeholder's forum was to provide participants with an opportunity to consider and discuss the key recommendations of the Diabetes Model of Care with particular reference to implementation. The following two workshop activities were utilised to enable participants consider some of the major implementation issues:

### 4.1 Activity One - Individual and Pairs

Participants were provided with worksheets detailing seven key recommendations from the Diabetes Model of Care. They were then asked to individually complete the sheets against the following criteria:

- Expected impact
- Feasibility of implementation
- Priority ranking

They then discussed and compared their responses and rankings with a partner.

### 4.2 Activity Two - Table Group Discussion

#### Barriers to implementation

Possible solutions to overcome the barriers (other than increased funding and/or human resources).

The seven table groups were provided with one recommendation to discuss in detail with particular reference to the following criteria.

- Barriers to implementation
- Possible solutions to overcome the barriers (other than increased funding and/or human resources)

Each table group were then asked to prioritise barriers and solutions.



## 5.0 WORKSHOP OUTCOMES

### 5.1 Activity one - Key recommendations: Expected impact, Feasibility of implementation, Priority ranking - Summary of individual and pairs responses.

Complete details of responses are shown in Appendix 2.

Key recommendation 1: Enhance community-wide and targeted promotion of healthy environment and lifestyle to prevent diabetes and increase awareness of the health impact of diabetes and its complications.

#### Expected Impact

- “Slow the obesity epidemic”. “Increase physical activity levels in the community.
- Important long-term issue. Slow change. Greatest potential (impact).
- Greater awareness of diabetes as a disease and its associated morbidity.

#### Feasibility of Implementation

Broad national agenda. Needs government buy-in at all levels. Network can advocate strongly for this. Govt/legislative measures to produce change and overcome resistance from industry/lobby groups e.g. food industry.

Long term goal. Need to change norms - healthy eating/physical activity.

Community planning, different models. Use successful models - with resourcing.

Priority ranking: 2

Key recommendation 2: Improve coordination of diabetes prevention and management services.

#### Expected Impact

- Reduced costs - avoid duplication of services and gaps in services, reduced rate of hospital admission.
- Increased patient safety. Reduce chance of missing areas of care. Patients not lost in the system. Increased access and efficiency. Reduced length of stay.
- Key element of program as it forms basis for a changed service model.
- Better health care provision in rural and remote areas. Timely access to service.

#### Feasibility of Implementation

- Engagement of providers/organizations to work together.
- Commitment to service planning that is common. Need to break down silo's between tertiary, GPs, NGOs.
- IT capability needs upgrading but also needs goodwill of practitioners to share records. Compatibility of systems. One system of communication.
- Requires extensive interaction between service providers and a general acceptance of a combined approach. Need overall framework.

Priority ranking: 1

Key recommendation 3: Ensure ready access to guidelines, protocols, decision aids and service directories for diabetes service providers and consumers.



### Expected Impact

- Consistent clinical practice and patient management. Will provide evidence-based decision support for all health care providers. Unify service provision.
- Standardised materials and education processes. Improved patient education.
- Clients receive/have access to non-conflicting up to date information.

### Feasibility of Implementation

- Should be easy to implement if clinicians ready to share. Feasible.
- Primary care interface critical for success.
- Build on work already done. Consider existing RACGP guidelines. Plenty of guidelines available - need to be adjusted to suit local services. Investigate what already exists in other states. Needs to be ongoing/up to date and sustainable.

Priority ranking: 6

Key recommendation 4: Develop information technology systems to improve communication between GP's and other service providers.

### Expected Impact

- Timely communication, therefore timely care. Improved communication between providers. Quick and simple referral of people with diabetes to local services. Would solve so many communication difficulties. Time saving.
- Continuity (and coordination) of care and reduced duplication. Reduced workload for GPs.
- Potential to greatly improve efficiency and quality of care. Targeting service.

### Feasibility of Implementation

- Divisions of General Practice ideally placed to facilitate. Divisions already have money to do this. GPs have various systems and in some cases, limited IM knowledge. Link with GP Divisions.
- Needs funding commitment and network infrastructure. Cost. PMH could do it - why not everyone?
- Would have to address privacy issues with elective transfer of data. Addressing community concern re access to personal data/information. Data security.

Priority ranking: = 4

Key recommendation 5: Review and reconfigure specialist services to improve access and maximize effectiveness.

### Expected Impact

- Will provide improved access and maximize effectiveness of services leading to better diabetes management and long-term outcomes. Improved equity in service provision. Early identification of problems.
- Better support and skills development for rural practitioners. Help build capacity of local GP's and other providers. GP's need to use EPC more. Clear referral point for GP's. Developing specialist role in support and crisis management.
- Timely treatment/intervention and management of severe complications. Reduced complications in higher risk populations. Reduced ED/hospital presentations.
- Reduce services at tertiary sites. Reduced costs associated with high risk groups. Reduced end-stage complications. Reduced complication risk and rates.



### Feasibility of Implementation

- Needs a coordinated plan and implementation strategy. Review scope of practice.
- Clinics need to be run in local areas throughout the Metro area. Primary health centres that are multi-disciplinary and linked to GP's based in the community.
- Need consensus across AHS's. Rearrangement of current system.

Priority ranking: = 4

Key recommendation 6: Increase investment in workforce training and development.

### Expected impact

- Overall will provide better and quicker access to services leading to long-term benefits for people with diabetes.
- Increase quality and effectiveness of service delivery. Minimise delays in diagnosis and treatment. Better patient management.
- Better management of diabetes across the entire health service leading to decreased LOS, decreased admissions and decreased complications. Equalise care.
- Increased workforce but must be coordinated. Need to consider more than medical model.

### Feasibility of Implementation

- Long-term strategy but need to start now. Needs to involve universities. Need to define requirement. Need to increase training places.
- Need to include GP's, especially in insulin initiation and management. GP Divisions can assist in the process.
- Can be done - phased approach with supporting \$\$ over time.

Priority ranking: 3

Key recommendation 7: Ensure ready availability of new technology for Type 1 diabetes.

### Expected impact

- Improved management of people with Type 1. Decreased/fewer complications and reduced morbidity. Positive impact on a small minority. Improved control.
- Better QOL for Type 1 diabetics and their families. Reassurance for diabetes sufferers.
- Reduce strain on the hospital system and allow for better patient self-management. Reduced hospital admissions.

### Feasibility of Implementation

- Feasible if available funding. Cost implications. Funding - equipment, staff, venues. Cost of technology. Need more government funding and workforce capacity. Through Medicare.
- Long-term. Pilot programs would be possible.
- Feasible. Work with government to achieve.

Priority ranking: 7

5.2 Activity two - Barriers and solutions - Table summary of priority responses.

Completes details of table responses are shown in Appendix 3.



**Table 1 - Improve coordination of diabetes prevention and management services**

Barriers	No one stop shop Lack of awareness
Solutions	Overarching credible structure/group - id gaps - support change ↓ duplication Decentralise 3° based hospital - and make community based with outreach capacity. Share resources (FTE) between 3°/2°/community health professionals Multidisciplinary service Mentor

**Table 2 - Enhance community-wide and targeted promotion of healthy environment and lifestyle to prevent diabetes and increase awareness of the health impact of diabetes and its complications.**

Barriers	Cost ++ Media Lifestyle/behavioural changes required
Solutions	Change in focus towards Prevention (DoH) Funding Education Working in Partnerships (e.g. Private Funds/GP's)

**Table 3 - Improve coordination of diabetes prevention and management services**

Barriers	Coordination) across different sectors Uniformity “ “ “ (integrated Medical records) Workforce education, supply, support integration, energy
Solutions	Position Numbers Attractiveness of job/area Centre of Excellence



Table 5 - Form advisory groups to develop, promote and audit use of guidelines, diagnostic protocols and information packages.

Barriers	Diverse but individualised Time consuming evidence based Who target → geography included, financing
Solutions	Use and endorse current models i.e. guidelines - instead of re-inventing the wheel Improve Primary care model and involve industry

Table 6 - Develop information technology systems to improve communication between GP's and other service providers:

Barriers	Agreement at high level providers True commitment from the system
Solutions	Adequate IT support Communicating with Health Care Givers Sourcing Expertise on I.T. requirements

Note: Tables 4 and 7 did not submit a table summary of priorities.



## 6.0 WHERE TO FROM HERE: ENDOCRINE HEALTH NETWORK AND DIABETES MODEL OF CARE

It is clear from the group's deliberations that the top priorities are to improve coordination of diabetes prevention and management services (Key recommendation 2) and to enhance community-wide and targeted promotion of healthy environment and lifestyle to prevent diabetes and increase awareness of the health impact of diabetes and its complications (Key recommendation 1). These priorities must be supported by enhanced information technology (Key recommendation 4) and workforce development (Key recommendation 6).

The responses from the second Endocrine Health Network Stakeholders Forum will be used by the Endocrine Health Network Executive Advisory Group (EAG) to inform the planning process, in consultation with health services, for the implementation of the Diabetes Model of Care. It is expected that a number of working groups will be established by the EAG to work with health services to develop action plans that will address agreed priority areas. Members of the Endocrine Health Network will be invited to participate in this process.



## APPENDICES

### Appendix 1 Forum Invitations and Attendance

Information about the workshop was circulated across the public health sector, to identified stakeholders and to those that had formally registered their interest in the Endocrine Health Network. More specifically, this included:

State-wide global email invitation and registration attachment sent to the public health sector;

Electronic invitations to key stakeholders and others registered on the Endocrine Health Network database; and

Coverage in the Health Networks Newsletter Netnews, which included workshop details and registration information.

More than 50 stakeholders attended the workshop from various sectors and disciplines including: endocrinology and diabetes, physiotherapy, Telehealth, primary care, consumers, population health, health promotion/physical activity, Pharmaceutical Council, podiatry, Country Health Services, non-government organisations, nursing, geriatrics, chronic disease management, diabetes education, Aboriginal health, child health, research, ambulatory care, epidemiology, tertiary and critical care, academia, general practice, dietetics, clinical governance, and non-government organizations.



## Appendix 2 Discussion responses - Activity 1

Key recommendation one - Enhance community-wide and targeted promotion of healthy environment and lifestyle to prevent diabetes and increase awareness of the health impact of diabetes and its complications.

Average pairs ranking for this recommendation = 3.0

Overall ranking for this recommendation = 2

### Expected impact

- Decreased risk factors, decreased incidence and prevalence (of type 2 DM).
- “Slow the obesity epidemic” “Increase physical activity levels in the community.
- Generally healthier society.
- Important long-term issue. Slow change. Greatest potential (impact).
- Focus on IFG/IGT group. Target at-risk populations. Earlier diagnosis.
- Impact on public opinion on the value of prevention. Knowledge improvement.
- High impact but change occurs gradually - social norms.
- Prevent or delay onset of diabetes. Prevention is better than cure.
- Fewer complications, hospital admissions.
- Help people make more educated lifestyle decisions. More educated community.
- Reduce cost of the service. The most important factor to reduce service demand.
- Greater awareness of diabetes as a disease and its associated morbidity.

### Feasibility of implementation

- Committed people to drive the community. Need dedicated staff.
- Broad national agenda. Needs government buy-in at all levels. Network can advocate strongly for this. Government/legislative measures to produce change and overcome resistance from industry/lobby groups e.g. food industry.
- Community planning, different models. Use successful models - with resourcing.
- Educate the public to deliver the message. Use NGO's. Many organizations, groups etc will need to give the same message. Keep messages simple.
- Need funding to provide education programs. Long-term strategies.
- Targeted promotion with young families through child and school health services”
- Promote good lifestyle/diet in WA Health. E.g. hospital food.
- Long term goal. Need to change norms - healthy eating/physical activity.
- Comprehensive population-wide education e.g. mass media. Integrate with diabetes education. Make campaigns more dramatic - hit the message home. Be aggressive.
- Several ways of promoting this through existing services. Coordinate better.
- Need to target early IGT from GP and primary care. GPs need to be on board.
- Needs ongoing persistent messages. State or national campaign through TV/radio, print media - requires \$\$ support from government.
- Set up prevention units at community venues with physiotherapists, dieticians, educators.

Key recommendation two - Improve coordination of diabetes prevention and management services.

Average pairs ranking for this recommendation = 2.3



Overall ranking for this recommendation = 1

#### Expected impact

- Reduced costs - avoid duplication of services and gaps in services, reduced rate of hospital admission.
- Increased patient safety. Reduce chance of missing areas of care. Patients not lost in the system .Increased access and efficiency. Reduced length of stay.
- Key element of program as it forms basis for a changed service model.
- Shifting emphasis away from hospital services and creating community environment to emphasize the patient. Transition services - timely option
- Could make a significant difference and quite quickly
- Staffing, specialist ED, access support, training. Better sharing of workforce.
- Better health care provision in rural and remote areas. Timely access to service.
- Best practice promoted and shared. Fewer traumas - increased satisfaction and quality of life.
- Improve GP understanding of referral options (and services) for their patients.
- Effective pathways for GPs to utilize. Less confusion for people with diabetes.
- Central, single point of referral to easily coordinate referrals. Consistency (and continuity) of care. Shared responsibility, shared resources.
- Emphasize self-management. Clinical support, peer support. Multidisciplinary development.
- If patient care was the priority for all current services they would become more complimentary rather than competitive. Essential to improve client journey.
- Standardisation of (electronic) communication and sharing of information across tertiary, primary (including GPs) and secondary services. Seamless patient journey Integration of data for better health outcomes. Patients journey able to be followed chronologically.
- Integration of diabetes education across disciplines.
- Sites would understand their role in the management of diabetes.
- Dedicated contact for rural areas (continuity). Support WACHS.
- Health promotion funding will be seen as a priority.
- Right place, right time, right location. One stop shop. Seamless service delivery.

#### Feasibility of implementation

- GP time and limitations (need to be considered). GP Divisions could assist. Central referral point for GPs to send diabetes patients then triage to appropriate services. GPs bombarded with new arrangements for service provision - will need to be very attractive and easy for GPs to implement. Up-skilling of GPs by endocrinologists through general practice.
- Only possible if workforce is available. Not difficult, just get on with it
- Readily implemented if area plans agreed. Need to get AHS's, WACHS on side. Probably 'easiest' to implement and tie in existing services.
- Transition process not well known - easy to inform all involved.
- Need to change funding structure to decrease competition.
- Should be easy to allocate regional responsibilities to specific tertiary and secondary care centres".
- Expand what is already used by NMAHS ambulatory care chronic disease teams.



- Difficult to implement as many services overlap and there are territorial issues which must be overcome”.
- Requires extensive interaction between service providers and a general acceptance of a combined approach. Need overall framework.
- Allows for sharing skill development.
- Need coordination point, common goal and buy-in from all services.
- IT capability needs upgrading but also needs goodwill of practitioners to share records. Compatibility of systems. One system of communication.
- Need to empower patients to take more responsibility for their care and the decisions they make.
- Need to include private providers or will be inefficient and will create duplication.
- Provide funding for programs and training of staff for this to occur.
- Should combine with other networks driving for same.
- Engagement of providers/organizations to work together. Commitment to service planning that is common. Need to break down silo's between tertiary, GPs, NGOs.
- Hard to coordinate State/Commonwealth/NGO services.
- Would also need adequate backend systems and processes for the smooth running of each of these initiatives.
- All diabetes teams in the community co-located. Have mobile team for small hospitals.
- Need a sound starting point (e.g. diabetes audit) that people can be added to.
- Various working parties coordinated by a central body.

Key recommendation three - Ensure ready access to guidelines, protocols, decision aids and service directories for diabetes service providers and consumers.

Average pairs ranking for this recommendation = 5

Overall ranking for this recommendation = 6

#### Expected impact

- Improved health outcomes. Increase early detection of diabetes. Decreased progression to complications. Decreased hospital stays.
- Standardised and optimized patient management.
- Improved health professional confidence.
- Consistent clinical practice and patient management. Will provide evidence-based decision support for all health care providers. Unify service provision.
- Standards of care in WA context very important.
- Standardised materials and education processes. Improved patient education.
- Clients receive/have access to non-conflicting up to date information.
- What is currently happening versus a systematic approach?
- Better and efficient management in the primary care setting.
- Better patient advice and ability to self-manage.

#### Feasibility of implementation

- Should be easy to implement if clinicians ready to share. Feasible.
- Primary care interface critical for success.



- Involve practice nurses to support GPs in linking with other community providers. Up-skilling of GP staff needed for this to work.
- Limited people on the ground. Possible in Metro.
- Would need all sectors including non-government to agree.
- Streamline education packages + get into hospitals + deliver.
- One central body to coordinate a register from which information packs are sent out. Needs to be done at a state level.
- Need for service evaluation. Lots of partners need to work together. Will work if full across-the-board cooperation and well promoted. Already have strong multi-disciplinary diabetes groups.
- Build on work already done. Consider existing RACGP guidelines. Plenty of guidelines available - need to be adjusted to suit local services. Investigate what already exists in other states. Needs to be ongoing/up to date and sustainable.

Key recommendation four - Develop information technology systems to improve communication between GP's and other service providers.

Average pairs ranking for this recommendation = 3.8

Overall ranking for this recommendation = 4(equal)

#### Expected impact

- Timely communication, therefore timely care. Improved communication between providers. Quick and simple referral of people with diabetes to local services. Would solve so many communication difficulties. Time saving.
- Seamless, client centred care. All receive same standard of primary care.
- Potentially high impact. Clear plans needed.
- One single set of information/records for each patient with diabetes. Current care plans are cumbersome. Better for referral & follow-up. Having care plans that can be contributed to by all providers (public and private). Able to view patient management, action plans, hospitalizations.
- Continuity (and coordination) of care and reduced duplication. Reduced workload for GPs.
- Must incorporate public and private primary, secondary and tertiary levels of care.
- Will be able to measure effectiveness of interventions and recording patients' progress. Monitor outcomes.
- Identification and recall of complex, at risk consumers.
- Potential to greatly improve efficiency and quality of care. Targeting service.
- Give access to information for providing and assisting in shared care.
- Better patient management across spectrum of health services.
- Register - accurate data for research. Able to easily contact diabetes patients (recall systems). Reduced loss of clients. Avoid individuals "slipping through". Help track mobile patient. Worthwhile.
- Reduce patient disenchantment associated with lack of communication between services. More patient involvement.
- Access to resources and knowledge base.
- Reduce modifiable risk.
- Help to act early to reduce complications.

#### Feasibility of Implementation



- Would have to address privacy issues with elective transfer of data. Addressing community concern re access to personal data/information. Data security.
- Need to be careful who enters data are clinicians or authorized and trained staff.
- Check other states e.g. Queensland.
- Long process: privacy, compatible systems, private/public firewalls, security access. Jurisdictional issues. Will GPs share records? Who owns the data?
- Needs funding commitment and network infrastructure. Cost. PMH could do it - why not everyone?
- Divisions of General Practice ideally placed to facilitate. Divisions already have money to do this. GPs have various systems and in some cases, limited IM knowledge. Link with GP Divisions.
- Most GPs have extractable data on diabetes prevalence and clinical outcomes.
- Needs to be a whole-of-health initiative. Is the workforce sufficient?
- Reliance of all providers to be online. Need lots of training.
- Initially difficult to establish and costly but once implemented should be easier to maintain.
- Allows effective review of patient management and advice.
- Coordination - what to do with the information. Patients all have different needs.
- NDSS - use as a starting platform for diabetes registers. T2 could follow T1. Negotiate with Federal Government for use of NDSS data.
- Make diabetes a notifiable disease to make register complete.

Key recommendation five - Review and reconfigure specialist services to improve access and maximize effectiveness.

Average pairs ranking for this recommendation = 3.8

Overall ranking for this recommendation = 4(equal)

#### Expected impact

- Will provide improved access and maximize effectiveness of services leading to better diabetes management and long-term outcomes. Improved equity in service provision. Early identification of problems.
- Timely treatment/intervention and management of severe complications. Reduced complications in higher risk populations. Reduced ED/hospital presentations. Reduce services at tertiary sites. Reduced costs associated with high risk groups. Reduced end-stage complications. Reduced complication risk and rates.
- Better support and skills development for rural practitioners. Help build capacity of local GP's and other providers. GP's need to use EPC more. Clear referral point for GP's. Developing specialist role in support and crisis management.
- Will reduce the cost and inconvenience of patients having to travel to Perth. Decreased length of stay.
- Specialists delivering specialized care closer to home - wellness model.
- Decreased morbidity and increased QOL for clients.
- Telehealth can provide coaching/management to all areas of WA.
- Need to be community- based to improve accessibility.
- Develop referral pathways to facilitate care.
- Improved acute care for outer metro, which can be worse than rural care.



## Feasibility of implementation

- Needs a coordinated plan and implementation strategy. Review scope of practice.
- Needs state and commonwealth support? Resources needed. Will take time. Will need funding to provide new specialist services.
- This underpins workforce model and needs to inform training programs for tertiary services.
- Possible now in secondary hospitals. Need integrated health centres in the community. Can be started within current resources.
- Needs to be done in conjunction with GP's/GP Divisions to prevent duplication.
- Complications screening - GP's and practice nurses need education and support to correctly identify and refer people at risk. Needs health provider education and up-skilling.
- Need consensus across AHS's. Rearrangement of current system.
- Expand on current phone coaching program.
- Moderate - effective for targeted groups. If specialists are willing to leave the hospital and provide the services locally then it is feasible.
- Clinics need to be run in local areas throughout the Metropolitan area. Primary health centres that are multi-disciplinary and linked to GP's based in the community.
- Will need co-operation and participation of GP's/primary care givers.
- Human resources possibly the biggest problem. Address workforce issues.
- Restructure chronic disease teams to provide crisis and insulin stabilization service with endo support.
- Expand RPH multidisciplinary foot ulcer clinic model to other sites e.g. Joondalup.

Key recommendation six - increase investment in workforce training and development.

Average pairs ranking for this recommendation = 3.6

Overall ranking for this recommendation = 3

## Expected impact

- Overall will provide better and quicker access to services leading to long-term benefits for people with diabetes. Increase quality and effectiveness of service delivery. Minimise delays in diagnosis and treatment. Better patient management.
- Would be excellent to know that all health professionals are well equipped to provide accurate information and advice - the correct advice.
- Better management of diabetes across the entire health service leading to decreased LOS, decreased admissions and decreased complications. Equalise care.
- Improved attraction of new staff and retention of existing staff. Greater job satisfaction. Retaining of staff very important. Opportunity for clinical growth.
- Expansion of endo training programs will have flow-on effects. More sustainable programs, especially in regional WA. Greater overall skill base in WA.
- Interdisciplinary learning. Role, responsibilities defined collaborative model.
- Instils confidence, skill and responsibility in health workers to tackle diabetes.
- To have sufficient clinicians specializing in these areas to provide the care and management required. Better access to specialist care in all areas.
- Use diabetes educators with previous in-service experience.



- High priority, especially Aboriginal Health Workers, dieticians and health promotion.
- Need positions for these people to work in. Essential for MOC implementation.
- Long term. In the short term invest in available workforce, esp. practice nurses.
- Increased workforce but must be coordinated. Need to consider more than medical model.
- Must have service models and 'map' operational framework.

#### Feasibility of implementation

- Long-term strategy but need to start now. Needs to involve universities. Need to define requirement. Need to increase training places.
- Tertiary institutions have a core training role. Reduce HECS to health courses as for nursing and teaching. Assistance with full fee training courses. Incentives for training - both individual and employer.
- Happening but needs greater funding and promotion.
- Need to develop generalist courses for more than just practice nurses.
- Can be started with some WA Health investment. More funding for positions.
- Need to include GP's, especially in insulin initiation & management. GP Divisions can assist in the process.
- Can be done - phased approach with supporting \$\$ over time.
- Significant impact on ensuring ongoing long-term clinical practice support.
- Where are the jobs in the northern suburbs? Many have completed training but no jobs.
- Community primary health centres to not only serve patients but also assist with inter-professional training and support. Create infrastructure and support for positions and then training.
- Difficult piece of work - endocrine health network to take lead.

Key recommendation seven - ensure ready availability of new technology for Type 1 diabetes.

Average pairs ranking for this recommendation = 6.8

Overall ranking for this recommendation = 7

#### Expected impact

- Improved management of people with Type 1. Decreased/fewer complications and reduced morbidity. Positive impact on a small minority. Improved control.
- Better QOL for Type 1 diabetics and their families. Reassurance for diabetes sufferers.
- Telemedicine options (in home).
- Improved quality of care, improved outcomes. Will be increasingly important for Type 1 care. Better care delivery. Better client outcomes.
- Reduced disadvantage. Equal access for all diabetics regardless of income status. More affordable technology for all.
- Need to establish if cost effective.
- Reduce strain on the hospital system and allow for better patient self-management. Reduced hospital admissions.



- Big individual impact, low overall impact. Impact on individuals rather than whole population.
- Increased need for HP's with new technology experience in remote, rural.
- Financial, process for eligibility.
- Best buy for buck is not this.
- Use current processes. Capitalise on Federal Election outcome

#### Feasibility of implementation

- Feasible. Work with government to achieve.
- Already access to pumps for < 25years through NDSS.
- Feasible if available funding. Cost implications. Funding - equipment, staff, venues. Cost of technology. Need more government funding and workforce capacity. Through Medicare.
- Long-term. Pilot programs would be possible.
- Done in tertiary/secondary. Would need support/information for community sector providers. Advice is free via the internet.
- Rapid technology change - outdated once selected.
- Measurable. Easy to monitor the impact.
- Training needed for statewide roll-out.



## Appendix 3 Discussion responses - Activity 2

TABLE 1

### Participants:

1. Maree Grant
2. Joey Kaye (co-facilitator, EAG member)
3. Sally Jennings
4. Julie Rennison
5. Kathryn Swain
6. Elizabeth Woodford
7. Jade Hart (co-facilitator)

### RECOMMENDATION:

#### *Improve coordination of diabetes prevention and management services:*

- Policy and programs for integrated diabetes services in AHS's.
- Efficient interface between community based diabetes services and local GP Divisions and other local diabetes care groups.
- Allocate regional responsibilities to specific tertiary and secondary care centres to ensure access to specialist multi-disciplinary teams.
- Establish systems to ensure timely communication between health care providers to assist transition between acute, primary and community care settings, including residential care services.
- Develop procedures to facilitate successful transition from paediatric to adult care.

### Table Feedback:

#### Barriers to Implementation:

- Fragmented service providers/inequity.
- No one stop shop.
- lack of awareness.
- Lack of coordination/communication.
- Providers/what exists - resistance to change.
- ^ IT.
- Access to service - specialist medical, nursing, allied health.
- Dependence on GPs to know everything including all relationships with Health Services.
- Who is responsible for this - co-ordination?
- Variation in information sharing across providers, public/provider/private provider barrier.
- Politics, turf.
- Possible Solutions to Overcome the Barriers.
- Overarching credible structure/group - id gaps; support change; duplication.
- Central service - GP can ring.
- Know services - FTE/Capacity; which one is quicker to access.



- Improve/identify IT solution - sell to all.
- Service providers & get them aboard.
- Establish trials which are long term.
- Mentoring new graduate health professional e.g. G.P. - Using Web based approach.
- Provide more accessible information.
- Provide service where needed.
- Decentralise 3° based hospital - and make community based with outreach capacity.
- Share resources (FTE) between 3°/2°/community health professionals.
- Multidisciplinary service.
- Mentor.
- Nurse Practitioners.
- Covering body to streamline/influence to change - filters down.

**Priorities:**

Barriers	<p>No one stop shop</p> <p>Lack of awareness</p>
Solutions	<p>Overarching credible structure/group - id gaps</p> <p style="padding-left: 150px;">- support change</p> <p style="padding-left: 150px;">↓duplication</p> <p>Decentralise 3° based hospital - and make community based with outreach capacity.</p> <p>Share resources (FTE) between 3°/2°/community health professionals</p> <p>Multidisciplinary service</p> <p>Mentor</p>



## TABLE 2

### Participants:

1. Frances Phillips
2. Ben Trewern \*
3. Julie Pearse \*
4. George Crisp (co-facilitator, EAG member)
5. Mary Duck
6. Shauna Gaebler (co-facilitator, EAG member)
7. Seng Khee Gan
8. Joel Gurr
9. Jenny John

### RECOMMENDATION:

*Enhance community-wide and targeted promotion of healthy environment and lifestyle to prevent diabetes and increase awareness of the health impact of diabetes and its complications.*

### Table Feedback:

#### Barriers to Implementation:

- Cost ++ Media
- Lifestyle/behavioural changes required.
- Delay in visible/measurable benefits.
- “It won’t happen to me” mentality.
- Money Spent on Treatment versus Prevention.
- (Δ Priority).
- Impact on campaign on limited workforce.
- Economic cost (Upfront).

#### Possible Solutions to Overcome the Barriers

- Real Life patients with complications.
- Multi-facet approach/strategies.
- Change in focus towards Prevention (DoH).
- Funding.
- Education.
- Re-designing Environment (e.g. Public Transport).
- Wide-reaching National Campaign - Understanding).
  - (Broad Brush).
- Reward Positive behaviour.
- Working in Partnerships (e.g. Private Funds/GP’s).



Priorities:

Barriers	Cost ++ Media Lifestyle/behavioural changes required
Solutions	Change in focus towards Prevention (DoH) Funding Education Working in Partnerships (e.g. Private Funds/GP's)



TABLE 3

Participants:

1. Maxine Schlaeppli
2. Nerida Croker (co-facilitator)
3. Kate Russell
4. Pixie Barrie
5. Tim Benson (co-facilitator, EAG member)
6. Anita Butler
7. Rob Haig
8. Tenille Myers

RECOMMENDATION:

*Improve coordination of diabetes prevention and management services:*

- Policy and programs for integrated diabetes services in AHS's.
- Efficient interface between community based diabetes services and local GP Divisions and other local diabetes care groups.
- Allocate regional responsibilities to specific tertiary and secondary care centres to ensure access to specialist multi-disciplinary teams.
- Establish systems to ensure timely communication between health care providers to assist transition between acute, primary and community care settings, including residential care services.
- Develop procedures to facilitate successful transition from paediatric to adult care.

Table Feedback:

Barriers to Implementation:

- Available workforce.
  - Funding State/Federal.
  - Specialist knowledge at grass roots level and support.
  - Public versus private - policies; guidelines.
  - (G.P., Hospital).
  - Integrated medical record Planning as part of usual job \*
- Coordination) across different sectors
  - Uniformity “ “ “
- Communication/continuity with G.P.
  - Different databases → I.C.T.
  - Role of G.P. in planning & implementing new services.
  - Lack of resources - human.
  - Multidisciplinary.



- Continuity processes across transition from paediatrics → adult services.
- Finding local “champions” & maintaining momentum to implement changes.

\* 

WORKFORCE → education, supply, support integration, energy
---

**Possible Solutions to Overcome the Barriers**

- Money



- Availability of Position Numbers - Create
- Attractiveness of job/area - incentives

e.g. - professional development - family/social support
---

- Education at grass roots.
- Supports

Coordination and continuity across different sectors
--

- Training and resources.
- I.C.T: ehealth record.
- Networking *JJ*.
- Virtual Centre of Excellence for best practice, resources, research.
- Dissemination.
- Policies, protocols, research.

**Priorities:**

Barriers	Coordination) across different sectors Uniformity “ “ “ (integrated Medical records) Workforce education, supply, support integration, energy
Solutions	Position Numbers Attractiveness of job/area Centre of Excellence



TABLE 4

Participants:

1. Bronwyn Middleton
2. Gwyneth Truran
3. Belinda Whitworth (co-facilitator)
4. Chloe Kearn
5. Mark Coles
6. Jennifer Duff
7. Maeva Hall
8. Sue Henning
9. Liz Kerrigan-Benson (co-facilitator, EAG member)
10. Beverley MacKay

RECOMMENDATION:

*Develop information technology systems to improve communication between GP's and other service providers.*

- Establish patient-centred electronic information systems linking multiple data sources from public and private providers.
- Assist GP's, specialists and other providers to provide individual patient management plans, and to establish recall systems and audit processes, particularly for vulnerable and high risk groups.
- Establish a register of all WA patients with type 1 diabetes
- Establish a register of all WA people with type 2 diabetes.

Table Feedback:

Barriers to Implementation:

- Pharmacy → Privacy electronic transfers of scripts.  
 → ? Encryption access.  
 → Central System Storage.

- Osborne Division: have database/referral form.  
 → adoption of electronic environment.

- GP's → If in Medical Director or similar they use:  
 → who does it → role of nurse.  
 → lack of ease of use lack of familiarity.

Lack of uptake

- Local versus State versus Commonwealth
- Competitive databases
- No incentive for Diabetes → one central database
- Timelines

Who has access?



→ Role of Practice Nurse (EPC)

- Incentives?? → Primary Care Collaboratives
- Communications Systems
- Care Planning / basic development
- Disconnect in gathering MDT data
- Lack of uniformity
- Duplication/repetitive
- Health Records not linked
- Pharmacists role in monitoring/surveillance
- Online prescribing | who is responsible?

Nurses

GP practices not component literate

- Lack of database to disease specific

Possible Solutions to Overcome the Barriers

Barrier

Referral only one part of it

- Patient journey, access to information

WoundsWest: | Midwest GP Division

Audit Review

Pharmacy Guild info on-line prescribing (background information)

What

National & International

\*doing

Intelligent diabetes Management System (IDMS) - what exists?

\*available

\*pilot

E-health → DoH

Diabetes (National Diabetes Services Scheme

NHS → What they doing

→ Links across chronic disease (co-morbidities)

\* Single point of referral and information for consumer, + carers + staff

Priorities:

Did not submit a table summary of priorities.



## TABLE 5

### Participants:

1. Marina Mickleson
2. Genevieve Stone (facilitator)
3. Marika Vajas
4. Gloria Daniels
5. Roslyn Francis
6. Elizabeth Howell
7. Alison Jones

### RECOMMENDATION:

*Form advisory groups to develop, promote and audit use of:*

- Risk assessment and early diagnosis protocols
- Type 1 and type 2 diabetes patient information packages
- Guidelines, protocols and local service directories for: optimal management of type 2, diagnosis and management of GDM, systematic early detection and management of complications, management during acute illness and in hospital inpatients, multidisciplinary specialist management of type 1 in collaboration with general practice.

### Table Feedback:

#### Barriers to Implementation:

- GPs are not funded for proactive responses to Pre-diabetes risk - e.g. EPC's through Commonwealth.
- Patient Education needs to be:
  - Standard.
  - Evidence based.
  - CALD sensitive/relevant.
  - Personalised.
- Literacy levels of many.
- Who do you target and in what settings e.g. GP's, Public & Private Practitioners.
- Shared patient records.
- Making sure information is current and regularly updated e.g. info on the internet with alternatives.
- Time to properly accommodate diverse groups esp. CALD.

#### Possible Solutions to Overcome the Barriers

- Use and promotion of Endorsed guidelines \* out there - increase access - Web, e.g. NMAHS - integrated diabetes Care Pathways.
- Redevelop and promote WA Diabetes strategy website.
- Involve industry in maintaining & implementation of health initiatives.
- Piggy Back other current services.
- Share Patients Records.
- Improve Primary Care Model to involve more and varied clinicians.



Priorities:

Barriers	Diverse but individualised Time consuming evidence based Who target → geography included! financing
Solutions	Use and endorse current models i.e. guidelines - instead of re-inventing the wheel Improve Primary care model and involve industry



## TABLE 6

### Participants:

1. Janmarie Michie
2. Mark Shah
3. Denise Smith (co-facilitator, EAG member)
4. Maureen Unsworth
5. Fiona Van der Berg \*
6. Carol De Groot
7. Mary Hervey
8. Tim Jones (co-facilitator, EAG member)
9. Megan Loneragan
10. Kylie Mahony

### RECOMMENDATION:

*Develop information technology systems to improve communication between GP's and other service providers.*

- Establish patient-centred electronic information systems linking multiple data sources from public and private providers.
- Assist GP's, specialists and other providers to provide individual patient management plans, and to establish recall systems and audit processes, particularly for vulnerable and high risk groups.
- Establish a register of all WA patients with type 1 diabetes.
- Establish a register of all WA people with type 2 diabetes.

### Table Feedback:

#### Barriers to Implementation:

- Confidentiality.
- Non Compatible systems: IT Complexity.
- Non Compatible data.
- Accessing Data e.g. NDSS.
- Patient Consent.
- Incorrect data/inaccurate data.
- Rural/remote access.
- Health Care provider collaboration/consent.
- Lack of Infrastructure.
- Agreement/consensus on data needed.
- Data entry/management



### Possible Solutions to Overcome the Barriers

- Adequate IT support communicating with health care givers.
- Agreement at high level providers A.
- Consent at diagnosis: Opt out.
- Sourcing expertise on I.T. requirements.
- Educating Health Care givers.
- Determining Data/Consensus.
- True Commitment from the system.
- Timeline to process.
- Diabetes a reportable disease.

### Priorities:

Barriers	Agreement at high level providers True commitment from the system
Solutions	Adequate IT support Communicating with Health Care Givers Sourcing Expert?? ? I.T. requirements



TABLE 7

Participants:

1. Sharron Meakins
2. Jane Pearce
3. Cherelyn Smith
4. Lorraine Wilson
5. Kim Goodman (co-facilitator)
6. Linda Hop (co-facilitator EAG proxy member)
7. Joanna Dodds
8. Dorothy Graham
9. Di Ledger

RECOMMENDATION:

*Review and reconfigure specialist services to improve access, maximise effectiveness and provide new specialised services, e.g.*

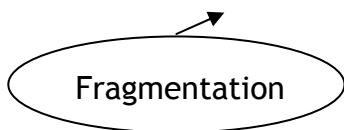
- crisis, insulin initiation, and high risk foot clinics.
- Outer metropolitan and regional outreach and Telehealth services.
- Complication screening services for high risk and vulnerable groups.

Table Feedback:

Barriers to Implementation

(shouldn't start with barriers "can do')

1. - all the tertiary based need  $\xrightarrow{\text{all}}$  community
  - current infrastructure for 1° care - different GP funding models
  - Commonwealth versus Federal funding



- Pharmaceutical companies - Paying for providing education services at GP rooms (why be suspicious of this sector?)

2. Fragmentation
  - need to be able to harness that.
  - Service - bring them in: QA Issues transparency
3. Hx partnering and politics. Adversarial relationship.

- Workforce - lack of expertise. Physician support. Allied health - different expertise/different services.
  - ↓
  - More work
  - More load



4. Outreach: PMH does it but not others.  
Outer metropolitan specialists don't go to regions - why not?  
Answer is to up-skill the GP's.  
Not endo's having to go out.  
Metro also a problem.

#### Possible Solutions to Overcome the Barriers

- Not just rural.
- Metro services - everywhere > 5 km Central Perth.  
'unmet need'.
  - but getting more GPs - double.
  - don't have the confidence - need to work on that.
  - | | move to primary + education + ongoing + access line.
  - Geographic alignment needed.
  - What holds the team together?
  - GPs very mobile - teams and relationships breakdowns.
  - Need to make practise protocols.
  - Advise clients to set up rapport with their GPs.
  - GPs not team players - why need all this information?
  - Need to get in to first two years of uni for attitudinal change - e.g. Medical students due a rotation in lactation consultancy.
- Telehealth:
  - takes very long
  - confidentiality a problem
  - good for case stuff but not for outpatients

(did a trial on people who were used to quarterly one on one assessment)

#### Priorities:

- Did not submit a table summary of priorities.



## CONTACT

To provide comment on this report and for all queries relating to the Endocrine Health Network please contact the Health Networks Branch:

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