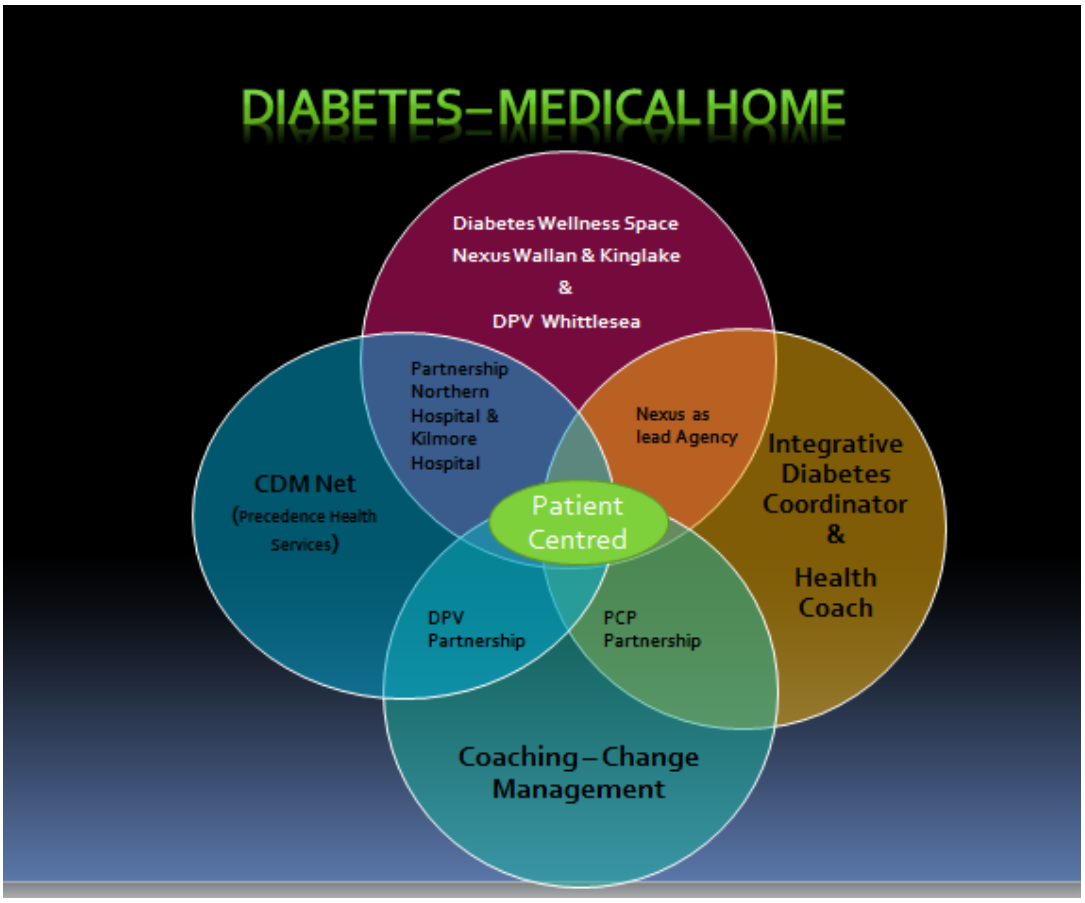
HWPCP evaluation case study 2018

Title of project

Diabetes Diversion Partnership Project (DDPP)

Partnership with Nexus Primary Health (Lead Agency), DPV Health, Precedence Health Services and Hume Whittlesea Primary Care Partnership based on a medical home model. Funding obtained through tender submission to Eastern Melbourne Primary Health Network. Integrated care model:



Start date

12 month project – commenced July 2018

What was the problem/challenge your project address?

The DDPP is engaging vulnerable populations (particularly patients with low socio-economic status, CALD and rural backgrounds, Indigenous Australians, and/or those with social isolation or mental health challenges) who have been diagnosed with Type II Diabetes and are at high risk of not managing their disease. Patients with frequent presentations to the Northern and Kilmore Hospitals will also be considered for the DDPP involving their usual GP where possible. The current health care system has significant structural impediments i.e. it is not patient centred, systems are fragmented (especially between primary and acute care) and there are problems with quality, with evidence that GPs could play a greater role in preventing chronic disease. This project has developed a model that delivers integrated, patient centred care.

What were the solutions/actions you put in place?

Identify target population at GP Clinics using POLAR technology

Engage Patients with Type II Diabetes in their healthcare to decrease their HbA1c level and to have an improved patient experience and improved patient outcomes, thus reducing demand for services and reduction in preventable acute and emergency department presentations.

What are the results/achievements? (include any data) (to date – project commenced Jul 2018)

Poster Presentation at 14th Australian Disease Management Association Conference 2018

Integrative Diabetes Coordinator and Health Coach have been employed

Patients with Type II Diabetes from participating GP Practices have been identified using POLAR technology

Looking forward – what are the next steps?

Patients identified with Type II Diabetes will be contacted by Practice Nurse from GP Clinic to explain DDPP and invite participation.

Each participant will have an individualised treatment plan developed with clear short and long term goals which will be monitored by both patient and care providers. Care will be coordinated.

The cdmNet platform will be utilised by both patients and providers.

Evaluation: Clinical outcomes; Patient experience; Clinician satisfaction, multidisciplinary care, preventable admissions, cost benefit that demonstrates value for money, use of digital health technologies.

Development of a sustainable service model. Look for further funding opportunities and share model with other services.

What is your key message for DHHS about this project (no more than 50 words)

DDPP demonstrates innovation in Whittlesea, Mitchell and Murrindindi in an integrated multidisciplinary diabetes care model, where treatment occurs in a community setting with system support. It increases capacity of partner agencies and potentially other GPs to manage diabetes in a community setting through effective client and clinician engagement and health outcome monitoring supported by technology.