INW PCP Diabetes Services Review Collaborative Project Evaluation: EXECUTIVE SUMMARY

Background

Between 2011 and 2012, the INWPCP undertook the *Diabetes Services Review Collaborative Project,* implementing an inter-agency approach to creating system level change, with the aim that people with type 2 diabetes receive the right service at the right time, in the right setting. Complications of diabetes represent the leading cause of avoidable hospital admissions throughout the inner north-west Melbourne region (Department of Human Services, 2014) and thus diabetes referral pathways were prioritised for the collaborative project. A group of local INWPCP member agencies collaboratively developed clear and consistent criteria for the level of care needs for diabetes and systemised referral in the region (Buchanan, 2013). Project partners included acute and community health agencies that provide services for people with diabetes in Melbourne's Inner North West.

This group has continued to meet quarterly since the finalisation of the project in 2012.

The main objectives of the project were to:

1. Develop a shared understanding amongst local diabetes services, of referral patterns and the system and practice changes required to improve continuity of care for people with type 2 diabetes, by July 2012.

2. Achieve greater consistency in local diabetes referral processes, through collaborative development of a referral pathway, including agreed referral criteria and feedback processes to follow when client referrals do not meet criteria, by December 2012.

3. Develop a consistent and clear message for General Practices in Melbourne's Inner North West, to guide referral to the appropriate community and hospital based services available locally to support people with type 2 diabetes, by December 2012.

4. Collaboratively develop a local inter-agency agreement, with an expression of commitment to guiding principles for implementation of the referral pathway by diabetes services, by December 2012.

Evaluation methodology

The evaluation methodology is based on an interactive evaluation approach. This approach is being increasingly adopted to answer the needs of stakeholders at the local level and contributes to the growth of social innovation by capturing the lessons learned and challenges for others to draw upon (Kwok, 2013). This model rests on the adequacy of local expertise to deal with local problems and assumes that external knowledge—and in particular accumulated research-based knowledge—is of lesser relevance than 'local' knowledge. It involves collaboration with stakeholders throughout the evaluation process and provides opportunity for feedback into the evaluation.

Summary of evaluation findings

This evaluation examines some of the longer term outcomes of the collaborative. The key interest for the collaborative is to understand to what extent the project achieved its primary aim of improving coordination and integration of services whereby clients are seen by the right service, in the right setting at the right time. The main aspects of the collaborative project that were part of the evaluation included a referral audit of the inter-referrals between the hospital agencies and community health, Google analytics, and qualitative reports from the group and their organisations.

The following quantitative data and qualitative themes emerged from the evaluation:

Key achievements:

The collaborative improved coordination of care for diabetic clients within the member agencies demonstrated by:

- Facilitating **ease and confidence with which referrals could be directed between its collaborative members** – particularly one hospital and community health service
- **Increasing overall referral** from hospital into community health services according to the referral guide developed
    i. In some instances referral from one hospital to one community health service (CHS) more than tripled from 2013 to 2014. The diabetes nurse educator attributed this increase entirely to their involvement in the collaborative.
    ii. One hospital reported that the referrals out to community increased 78 Fold (0 in 2011 to 78 in 2014) which resulted in an increase in appointments for new clients
- Google analytics indicated the **guide was accessed** to some degree on two out of the three websites locations it was placed.
- The collaborative project saved resources and time through improving availability of appointments for clients requiring diabetes education in the hospital setting
- A project that has been **sustained for 4 years** with engaged and devoted members that have mutual respect for each other.

The referral audit – key points

A referral audit conducted in April 2015 indicated that the referral form was used consistently between collaborative members (83%). Referral acknowledgments were made back to the hospital by collaborative members 72% of the time.

- Acknowledgements within the collaborative were significantly higher than the average acknowledgements returned from other community health services outside the collaborative of 17% (n = 13).
- Qualitative reports from the collaborative indicated the improvement work in inter-referral between hospitals and CHS was a direct result of involvement in the collaborative project.

The majority of clients referred from hospital to CHS were seen in the designated time frame given by the hospital and could also be directed to other suitable services.

Recommendations

The following recommendations could be considered when planning any future directions:

1. The referral guide continues to be housed on the INWPCP website and continues to be updated regularly by the INWPCP based on the input from the collaborative.
2. Consider completion of a second audit similar to the one completed in 2012, to see if hospitals are getting inappropriate referrals and percentage of referrals lacking information.
3. Collect consumer stories and client outcomes to capture an insight into the value of the project's outcomes from the consumer perspective.
4. Continue to progress system level improvements in local diabetes care using the Diabetes Services Review Collaborative Network's well established partnership platform. Opportunities recently identified by the Network include the adoption of e-referral and secure messaging systems as a means to further improve local diabetes referrals.

"The diabetes collaborative project has implemented many changes at both the individual and organisational level. They have sustained their efforts for several years and are a shining example of commitment and passion from all members involved." Project partner