Final Project Report

Inner North West Diabetes Services Review Collaborative

<table>
<thead>
<tr>
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<th>Details</th>
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<th>Contact</th>
<th>Phone</th>
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<tr>
<td>Hospital Endocrinology Education</td>
<td>25 patients with Type 1 diabetes. Treatment with diabetes complications.</td>
<td>St Vincent's hospital</td>
<td>Tel. (03) 9389 2263</td>
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<td>Hospital Admission Risk Program (HARP)</td>
<td>Patients with Type 1 diabetes admitted.</td>
<td>Royal Melbourne hospital</td>
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<td>Community Health</td>
<td>Type 2 diabetes, diabetic renal disease &amp; nephropathy</td>
<td>Austin Health and Community Health Services</td>
<td>Tel. (03) 9389 2263</td>
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<tr>
<td>Private Allied Health Providers</td>
<td>100 people with private health insurance</td>
<td>Image Health</td>
<td>Tel. (03) 9389 2263</td>
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</tr>
</tbody>
</table>

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Reported to: INW PCP Chronic Disease & Service Coordination Alliance &
INW PCP Diabetes Services Review Collaborative Project Group

Submitted on: 16th January 2013
Acknowledgements

The Inner North West Primary Care Partnership provided project coordination and funded consultant Marie Gill to facilitate the 12 workshops. Project coordination occurred in collaboration with representatives from participating agencies. The INW PCP Chronic Disease & Service Coordination Alliance oversees the operational activity of the PCP under the strategic priorities for integrated chronic disease management and service coordination. The project team undertook project activities throughout the series of 12 facilitated workshops.

Collaborating agency programs:

- Doutta Galla Community Health Service
- Hospital Admission Risk Program, Melbourne Health
- Hospital Admission Risk Program, St. Vincent’s Health
- impetus Progressive Primary Health
- Inner East Community Health Service
- Inner North West Melbourne Medicare Local
- Inner North West Primary Care Partnership
- Melbourne General Practice Network
- Merri Community Health Service
- North Richmond Community Health Service
- North Yarra Community Health Service
- Royal Melbourne Hospital Diabetes Education Unit
- St Vincent’s Hospital Diabetes Education Unit

For further information about the Inner North West Diabetes Services Review Collaborative Project or the resources developed, please contact the Inner North West Primary Care Partnership on T: (03) 9389 2263 or refer to the website www.inwpcp.org.au
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Executive Summary

Background
Increasing prevalence of diabetes and related health complications, combined with growing service demands and inappropriate referrals, were the impetus for Inner North West Primary Care Partnership (INW PCP) member agencies to agree to work together on developing a more coordinated approach to service delivery. This project report describes a local 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. Project partners included acute and community health agencies that provide services for people with type 2 diabetes within the INW PCP catchment.

Approach
A planning workshop, involving eleven local agencies, identified current service criteria, practice issues and barriers to improving diabetes care in the catchment. Five key improvement strategies were prioritised. The INW PCP coordinated a twelve month program of action oriented workshops, supporting agencies to work on implementing these improvement strategies. The ‘Plan, Do, Study, Act’ (PDSA) quality improvement framework was used to guide the planning and implementation process. At each workshop, agencies collaboratively solved problems and planned system level improvement strategies. Agreed strategies were then canvassed and or trialled within each organisation. Participants shared learnings and modified planned changes, to ensure improvement strategies would be relevant to, and adopted by, all agencies. The opportunity to collectively examine issues, identify and trial possible improvement strategies within agencies and discuss implications, has supported the development of a local diabetes referral pathway.

Outcomes
Throughout the twelve workshops, participating agencies have achieved the following results:

- Built a shared understanding of local system and practice changes required to improve service coordination and care for clients with type 2 diabetes
- Formed a strong professional network between local diabetes service providers and common ground for future service improvements
- Two public hospitals in the catchment have agreed on common referral criteria for outpatient diabetes clinics, and referral pathways for people who do not meet the criteria
- Developed an agreed type 2 diabetes referral pathway in Melbourne’s Inner North West
- Developed a local inter-agency agreement, outlining an expression of commitment and agreed guiding principles for ongoing use of the referral pathway
- Committed to meet on a bi-annual basis, to review the implementation of the Adult Diabetes Referral Pathway and the Inter-Agency Agreement.

The Collaborative has agreed and committed to a set of guiding principles for the implementation of the Adult Diabetes Referral Pathway (Appendix 1), and for sustaining the achievements of this project. This is outlined in the Inter-Agency Agreement provided in Appendix 2.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CHS</td>
<td>Community Health Service</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HARP</td>
<td>Hospital Admission Risk Program</td>
</tr>
<tr>
<td>HITH</td>
<td>Hospital In The Home Program</td>
</tr>
<tr>
<td>ICDM</td>
<td>Integrated Chronic Disease Management</td>
</tr>
<tr>
<td>INWMMML</td>
<td>Inner North West Melbourne Medicare Local</td>
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<tr>
<td>NWMR</td>
<td>North West Metropolitan Region</td>
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<tr>
<td>PAC</td>
<td>Post Acute Care Program</td>
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<td>PDSA</td>
<td>Plan Do Study Act</td>
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</table>
Introduction

INW PCP Strategic Plans
The INW PCP established and coordinated this inter-agency partnership project, in alignment with the INW PCP Strategic Plan 2010-2012. The project relates to the ICDM objective:

To support evidence-based quality improvement initiatives through the collaboration of partner agencies to develop integrated and coordinated systems within and between services.

Background
Diabetes represents the leading cause of avoidable hospital admissions across Inner North West Melbourne (Victorian Department of Human Services, 2011). It is the fourth highest cause of avoidable mortality and is amongst the most prevalent chronic conditions for people living in this catchment (Australian Bureau of Statistics, 2009). Increasing prevalence of diabetes and related health complications, combined with growing service demands and perceived inappropriate referrals, were the impetus for Inner North West Primary Care Partnership (INW PCP) member agencies to agree to work together on developing a more coordinated approach to service delivery. This project report describes a local 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. Project partners included acute and community health agencies that provide services for people with type 2 diabetes within the INW PCP catchment.

An earlier Diabetes Services Review Workshop in April 2011 brought together eleven local diabetes services, identifying current practice issues and barriers to improving diabetes care in the catchment. Out of this workshop 5 priority strategies were identified:

1. Work with community health services (CHS), hospital services and Hospital Admission Risk Program (HARP) to better feed back to GPs via written and verbal communication
2. Community/HARP services to work together with hospital services (and GP Divisions) to make the referral process quicker and easier
3. Community Health Services to better articulate to GPs the benefit of their integrated services (and address myths or perceptions about CHS’s that may be false or out of date)
4. Investigate the various discharge planning teams/services at Royal Melbourne Hospital (including HITH and PAC) and market the HARP and community services to them
5. Ensure all adequate information is received with referrals, to allow prioritisation and reduce the need to go back to the referrer for more information.

The INW PCP recruited further representatives from diabetes services across the catchment to form a partnership project. Participants selected a number of the strategies above to drive a coordinated approach to system improvement.
Collaboratives & PDSA Methodology

The INW PCP reviewed a number of previous and existing partnership projects when selecting the project methodology, including the successful Improving the Diabetes Journey Project (ItDJ) coordinated by the Inner East Primary Care Partnership (Inner East Primary Care Partnership, 2011). On this basis the ‘Plan, Do, Study, Act’ (PDSA) quality improvement framework was adopted. Lessons learned from previous PCP projects, specifically targeted to achieving improvements in diabetes services, were utilised to enhance planning and implementation of this project.

A collaborative is a quality improvement strategy to support implementation of system and practice change through sharing of experience and knowledge, over a set period of time (Wilson, Berwick & Cleary, 2003). PDSA cycles are an important part of the Collaborative Methodology which can be implemented through a workshop based approach. Collaboratives operate by bringing together organisations to look at how to improve care for a designated condition or long term care process and involve joint planning and problem solving in order to explore and implement strategies.

Consultation and Engagement

A number of meetings were held with the Endocrinology Units from each of the two participating metropolitan hospitals, to discuss the project brief. Acknowledgement and support of the project’s approach was obtained from both Endocrinology Units.

Agency representatives were recruited to the collaborative, via program managers from local diabetes services, as identified through a stakeholder analysis process. Please see current Stakeholder Analysis provided in Appendix 3.

A detailed project brief was used to guide project planning and communicate the scope and approach to program managers. Upon recruitment, collaborative participants received a 2 page overview of the project describing the project approach and outlining the workshops.

The INW PCP Project Coordinator emailed reminders to participants one week prior to each scheduled workshop and a workshop summary for participants and engaged project managers each month.

The two local Divisions of General Practice, Melbourne General Practice Network and impetus, were represented in the Collaborative from the onset of the project. This representation continued throughout the emergence of the Inner North West Melbourne Medicare Local, as both participants were employed by this Medicare Local. Representation by the Divisions of General Practice, and now the Medicare Local, has continued to provide the General Practice perspective throughout PDSA.
cycles and to advocate for alignment of project deliverables with standardised service coordination tools. The Medicare Local representatives have provided a valuable link to General Practice, completing an early survey to capture perceptions amongst local General Practices regarding community based diabetes service referral options. The Medicare Local representatives were also able to capture feedback from General Practices during development of the Adult Diabetes Referral Pathway.

Governance
Governance arrangements included provision of a bi-monthly summary of the project’s progress to the INW PCP Chronic Disease and Service Coordination Alliance, the group of member agency representatives who oversee the operational activity under the strategic priorities for integrated chronic disease management and service coordination.

Project Aims and Objectives

The overarching goal of this project is to achieve improved diabetes service coordination and integration, whereby clients are seen by the right service, in the right setting at the right time. A Project Logic Model was developed to guide project planning, implementation and evaluation. This is provided in Appendix 4. The project sought to achieve this goal through the following objectives:

1. To 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. To 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. To 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. To 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.
Key Stakeholders

The project has included representatives from organisations and programs providing services for people with diabetes across the Inner North West PCP catchment which includes the local government areas of Melbourne, Moonee Valley, Moreland and Yarra. The Stakeholder Analysis Table is provided in Appendix 3.

An important stakeholder group of course, are the people in Melbourne’s Inner North West who have type 2 diabetes. A concurrent project has been underway in Melbourne’s North West Metropolitan Region (NWMR) called CASE-D, *Care and System Experiences of People with Type 2 Diabetes*. The CASE-D Project is a partnership project between The Melbourne University’s Department of General Practice, The Department of Health NWMR and four local primary care partnerships. Many of the collaborative project’s participants were also engaged in the CASE-D Project.

Through the CASE-D project, a number of local people who have type 2 diabetes shared stories about their diabetes care. The resulting de-identified narratives were presented to diabetes service providers through a series of workshops prompting reflection on consumer perspectives, current systems of care and potential system improvements. These consumer perspectives strongly reinforced the aims of the Inner North West Diabetes Services Review Collaborative Project, with the need for truly integrated care, delivered in the most appropriate setting, validated as important themes for local consumers. One consumer described the transition of his care from the hospital, “...It took me three, roughly three to four years... so many thousands of visits...I went backwards and forwards to the hospitals to see different specialists in all their fields” to his local community health service “...my GP’s got me in a circle of five people... he said there is three to five people connected in the whole system to me”. This same consumer describes the communication between the primary care services he sees, “[My GP’s] the main leader and then they all report back to him all the time and that way he keeps me in the middle” (Department of General Practice, The University of Melbourne, 2012).
The Workshops

The Collaboratives methodology uses PDSA cycles to guide and drive change, enabling participants to test small changes and refine an approach before implementation (Cretin, Shortell & Keeler, 2004). The INW PCP coordinated a twelve month diabetes improvement program using the Collaborative Methodology. This involved the following:

- An initial planning workshop, involving eleven local agencies, identified current practice issues and barriers to improving diabetes care
- The PDSA quality improvement framework was used to guide the planning and implementation process
- Workshops were held monthly for 2-3 hours, where agencies collaboratively solved problems and planned system level improvement strategies
- The workshops were delivered by an external facilitator experienced in diabetes system change and were action orientated, supporting agencies to work toward implementing agreed improvement strategies
- Between workshops, agreed strategies were canvassed and trialled within/across agencies
- In the following workshop, participants shared learnings and modified planned changes, to ensure improvement strategies were relevant to, and adopted by, all agencies

Results

PDSA Cycle Reports

PDSA cycles submitted to the INW PCP Project Coordinator each month provided documentation of each small change tested and the outcomes. PDSA activities undertaken by the collaborative group during the project included:

- Service mapping (including services available, referral patterns and criteria etc)
- Identifying referral and intake processes
- Identifying triggers for referral from different stakeholder perspectives
- Surveying a small sample of General Practices to identify triggers for referral to Community Health
- Meeting with Endocrinology Unit representatives to obtain agreement on diabetes outpatient clinic referral criteria and on a protocol for referrals not meeting criteria to be redirected to the appropriate service
- Identifying levels of diabetes care available in the catchment, guided by the ItDJ Type 2 Diabetes Priority Pathway Tool
- An audit of referrals to Royal Melbourne Hospital and St. Vincent’s Hospital Endocrinology Diabetes Outpatient Clinics to identify the number and source of inappropriate referrals
- Establishing the current waitlist for Community Health Services and the feasibility of achieving the timeframes of the ItDJ Type 2 Diabetes Priority Pathway Tool
- Developing a suite of tools to support referral redirection, including a referral form, GP and patient letter template
- Redirecting referrals not meeting Endocrinology Diabetes Outpatient Clinic agreed referral criteria (and logging these redirected referrals to cross check with receiving agency)
- An audit of planned discharges from one Endocrinology Diabetes Outpatient Clinic
- Developing an Adult Diabetes Referral Pathway using information tested and agreed through this project
- Developing an Inter-Agency Agreement to support ongoing maintenance and implementation of agreed referral processes

Further post project evaluation is planned to monitor the impact of the Adult Diabetes Referral Pathway, the supporting resources and the Inter-Agency Agreement. This includes an audit that will be conducted in December 2012 and March 2013 by one metropolitan hospital, which will include the number of redirected referrals.

Key project deliverables:

Adult Diabetes Referral Pathway
Through the workshops outlined above, an agreed Adult Diabetes Referral Pathway was collaboratively developed by project partners. Please see attached in Appendix 1. This referral pathway will act as a decision support tool, which provides a guide to finding the right level of care for adults with diabetes in Inner North West Melbourne. The pathway will be promoted as a tool for General Practices.

To support the implementation of the Adult Diabetes Referral Pathway, a suite of resources were developed as follows. For further information, or to access copies of these resources, please contact the Inner North West Primary Care Partnership on T: (03) 9389 2263.

Diabetes Education Referral Redirection Form
A single page letter template that can be used when a diabetes referral is received for a client that does not meet the service criteria on the Adult Diabetes Referral Pathway. The completed template is then sent to the appropriate diabetes service, redirecting the referral. There is a fax back acknowledgement prompt.

Client Letter Template
A single page letter template that can be sent to clients, explaining that their referral has been redirected to a particular service. This letter can be sent with the Community Health Diabetes Services Brochure, described below, informing the individual of the services available through Community Health to support diabetes management.
Community Health Diabetes Services Brochure
A two sided, A4 sized brochure that describes the community health based diabetes services available in Inner North West Melbourne. This brochure can be provided to clients at the point of referral redirection, encouraging the client to discuss community based service options with their General Practitioner.

GP Letter Template
A single page letter template, advising the client’s General Practice of the referral redirection. This template can be completed by the acute hospital’s triage service and sent to the client’s General Practice.

Inter-Agency Agreement
An agreement outlining an expression of commitment and agreed guiding principles for ongoing use of the referral pathway. Please see Appendix 2.

Attendance
The twelve workshops were consistently well attended with an average attendance rate of 73% over the twelve months. Over the course of the project no agencies withdrew their participation. One agency became involved from the 9th workshop onward, this was due to limited capacity to be involved at the onset of the project.

Participant Evaluations
A collaborative participant survey was conducted to measure self reported perceptions about the inter-agency partnership, the project process and the deliverables against the project objectives. The participant survey results indicate participants felt that the project has been successful in:
- Establishing and strengthening professional links with other diabetes services in the catchment
- Improving participant understanding of local diabetes referral patterns and levels of care
- Developing a shared understanding of local system and practice changes required to improve diabetes continuity of care
- Applying a coordinated approach to local diabetes service improvements.

A separate evaluation survey was conducted with the program managers who have been engaged in the project through monthly emailed progress updates. Feedback from managers indicated that the project had been successful in strengthening the network between participating diabetes service providers and in introducing an effective change management methodology. It was acknowledged that a barrier to progressing this work has been the lack of an authorising environment between senior leadership of participating agencies.
### Expenditure

**INW Diabetes Service Review Collaborative Budget**

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<th>$ Actual</th>
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<td>Facilitator x 12 Workshops</td>
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<td>Catering $6/head x 15 x 12 sessions</td>
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<td><strong>Total</strong></td>
<td><strong>14470</strong></td>
<td><strong>13591</strong></td>
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The INW PCP funded these project costs. The Melbourne General Practice Network (MGPN), Inner North West Primary Care Partnership (INW PCP) and Inner North West Melbourne Medicare Local (INWMML) meeting rooms were utilised for workshops free of charge. Expenditure for materials was lower than expected due to the decision to provide electronic rather than printed copies of the participant workbook. Catering expenses were also much lower than expected due to a decision to prepare fruit and cafe biscuits/slices rather than pre-order professional catering.

### Discussion

The Inner North West Diabetes Services Review Project has developed a strong local partnership that has been able to progress system improvement for diabetes care. The opportunity to collectively examine issues, identify and trial possible improvement strategies within agencies and discuss implications, has supported the development of an agreed local pathway for people with type 2 diabetes and provides a strong partnership and common ground for future service improvements.

Key success factors include support from program managers who allowed participating staff to have dedicated time to spend on this system improvement work. The General Practice perspective, provided through involvement of two local Divisions of General Practice and now the Medicare Local, has also contributed to the project’s successes to date.

Challenges have included the lengthy process to reach a shared understanding of our complex service system. However, this vital investment of time has been a necessary enabler for system change. It is acknowledged that a limitation of this project is that it focused on the development of system improvements by local community health and hospital program representatives. While private primary care providers are featured as a service option on the Diabetes Pathway, private providers were not represented on the collaborative project. There is an opportunity for future stages of improvement work to include private primary care providers.
In developing the pathway there was a need to reach consensus between service types, on shared referral criteria. For example, agreement was sought between the two participating hospitals, on common criteria for referral to their respective diabetes outpatient clinics. Over a number of PDSA cycles, referral and discharge patterns were audited within each hospital diabetes outpatient clinic. Results demonstrated that these clinics were seeing patients who could be more appropriately receiving their diabetes care and support in the community health setting. This data was presented to internal inter-departmental meetings, demonstrating the need for an agreed common criteria and a process for redirecting referrals not meeting the criteria to the appropriate service. Based on this work, agreement on a shared criteria and referral redirection process was achieved and now referrals received by these hospital clinics that do not meet their eligibility criteria are redirected to the appropriate community based diabetes service. The client will receive a letter explaining this redirection and a brochure outlining community based services available to help support diabetes management. The General Practice will similarly receive a letter advising of the redirection.

**Workshop Outcomes & Change Areas**

Throughout the 12 workshops, participating agencies have achieved the following:

- Built a shared understanding of local system and practice changes required to improve service coordination and care for clients with type 2 diabetes
- Formed a strong partnership and a consistent approach to diabetes service improvement
- Two public hospitals in the catchment have agreed on common referral criteria for outpatient diabetes clinics, and a referral pathway protocol for people who do not meet the criteria
- Developed an agreed type 2 diabetes referral pathway in Melbourne’s Inner North West
- Developed a local inter-agency agreement, outlining an expression of commitment and agreed guiding principles for ongoing use of the referral pathway

The following example is provided to demonstrate the use of the Adult Diabetes Service Review Pathway and supporting resources during the project, for a local individual with type 2 diabetes. Concurrently, the pathway will be promoted to local General Practices to guide referral directly to community based diabetes services, where this is appropriate.
A. A local General Practice refers a patient to a large metropolitan hospital diabetes outpatient clinic, for insulin initiation and stabilisation
B. The hospital triage determines the referral to be inappropriate for the outpatient diabetes clinic, based on criteria that include those on the agreed pathway
C. Based on the pathway, it is identified that the client can receive the necessary care and support from their local community health service and the referral is redirected to this service. This redirection document includes a prompt for the receiving service to provide an acknowledgement of receipt of referral
D. The General Practice receives notification of the redirected referral via a letter
E. The consumer receives notification of the redirected referral via a brief letter and a brochure outlining community health based services for diabetes support and care.

**Status and Sustainability**

The Collaborative has agreed to meet on a bi-annual basis, to review the implementation of the Adult Diabetes Referral Pathway and the Inter-Agency Agreement. These meetings will provide an ongoing opportunity for inter-agency collaboration and communication, building upon the strong partnerships established through this project.

There are plans to audit the number of hospital referrals redirected to the community in December 2012 and again in March 2013. The results of these audits will demonstrate the project’s impact on diabetes referrals reaching the appropriate service setting for the needs of the consumer.
To date, the progress and findings of the project have been communicated as follows:

- A bi-monthly summary of the project’s progress has been shared with the INW PCP Chronic Disease & Service Coordination Alliance, the group of member agency representatives who oversee the operational activity under the strategic priorities for integrated chronic disease management and service coordination
- A number of project updates have been shared through the INW PCP e-Newsletter
- A conference poster was developed to share the project approach and progress. In September 2012 one representative from the collaborative presented the project at the Australian Diabetes Educators Association (ADEA) Conference on the Gold Coast and another representative presented the poster at the Australian Disease Management Association (ADMA) Conference in Melbourne
- The poster was also showcased at the Inner North West Chronic Disease & Service Coordination Forum in November 2012
- Upon conclusion of the project in December 2012, this Final Project Report and all project deliverables including the Inter-Agency Agreement will be disseminated to all key stakeholders.

**Recommendations for Ongoing Work and Implementation**

The following recommendations are made for ongoing work and implementation:

1. The Collaborative has agreed to meet on a bi-annual basis, to review the implementation of the Adult Diabetes Referral Pathway and the Inter-Agency Agreement
2. Promotion of the pathways to general practices and monitoring of general practice use of the referral pathway and their responses to redirected referrals
3. Consumer research to gauge consumer response to redirected referrals and experiences of the services they access
4. Monitoring of service utilisation across the system
5. Monitoring of redirected referrals from acute to community health to ensure timely and appropriate service delivery
6. Continue to explore opportunities to improve referral pathways between services
7. Explore opportunities to develop shared care plans across services and with general practice.
Conclusion

The Inner North West Diabetes Service Review Collaborative Project has been a local 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. Implementing system changes to improve care coordination across multiple agencies is complex. Guided by the PDSA quality improvement framework, a local partnership has been developed that has been able to progress diabetes system improvement in Inner North West Melbourne. Participants from this collaborative report one of the key project achievements to date has been the development of a strong partnership network between local diabetes service providers, particularly the hospital-community health connections that have been strengthened. These partnerships provide a strong foundation for future collaboration with member agencies, including the new Inner North West Melbourne Medicare Local.

The opportunity to collectively examine issues, identify and trial possible improvement strategies within agencies and discuss implications, has supported the development of an agreed local pathway for people with type 2 diabetes and provides common ground for future service improvements.

An inter-agency agreement outlining an expression of commitment and agreed guiding principles for ongoing use of the referral pathway has been developed. The collaborative group have agreed to meet bi-annually to collectively review referral patterns and processes for people with type 2 diabetes in Melbourne’s Inner North West.
References


Department of General Practice, The University of Melbourne 2012, Final Report: CASE-D Care and System Experiences for People with Type 2 Diabetes in the North & West Metropolitan Region. (Awaiting publication).


Appendix 1: Inner North West Adult Diabetes Referral Pathway

## Adult Diabetes Referral Pathway

*General Practice can access one, or multiple, pathways for integrated diabetes care, depending on the level of support required by the patient.*

<table>
<thead>
<tr>
<th>Service type</th>
<th>Criteria</th>
<th>Contacts</th>
<th>Fax</th>
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</table>
| **Hospital Endocrinology and/or Education** | • All patients with Type 1 diabetes.  
• Type 2 with diagnosed diabetes complications.  
• Type 2 for medical opinion on intensifying diabetes management. | St Vincent’s Hospital  
T: 9288 2211 [www.svhm.org.au](http://www.svhm.org.au)  
Royal Melbourne Hospital  
| **Hospital Admission Risk Program (HARP)** | Adults who have Type 1 & Type 2 diabetes and:  
• Complex care and social factors impacting ability to self manage  
• Hospital admission in past 12 months  
• Imminent risk of hospitalisation  
• Diabetes education, insulin initiation & stabilisation. | Partnerships In Health, Melbourne Health HARP  
T: 9342 4530 [www.mh.org.au](http://www.mh.org.au)  
Royal Melbourne Hospital HARP Diabetes Foot Unit  
T: 93432 7134 [www.mh.org.au](http://www.mh.org.au)  
Restoring Health, St Vincent’s Health HARP  
| **Community Health** | Type 1, Type 2 & pre-diabetes requiring:  
• Education/Insulin initiation & stabilisation  
• Diabetes education  
• Support with lifestyle change and motivation  
• Coordinated multi-disciplinary approach to complement GP care plan  
• Selected Medicare services (available some Community Health Services)  
• Support to self manage, or group education  
• Support to deal with social isolation, or mental health issues  
• Exercise, social and activity groups  
• Diabetes Prevention Programs  
• Access to low cost services. | Merri Community Health Services  
Doutta Galla Community Health  
T: 8378 3500 [www.doutta.org.au](http://www.doutta.org.au)  
North Yarra Community Health  
T: 9411 4333 [www.nych.org.au](http://www.nych.org.au)  
North Richmond Community Health  
Inner East Community Health  
| **Private Allied Health Providers** | • Fee for service.  
• For people with private health insurance.  
• Certain Medicare-registered allied health services, including credentialed diabetes educators, are available where the patient is managed by the doctor under a GP Management Plan & Team Care Arrangement (EPC). | Search for services on: [http://humanservicedirectory.vic.gov.au](http://humanservicedirectory.vic.gov.au) | |

*Current March 22nd, 2013. Updated copies can be sourced from Inner North West Melbourne Medicare Local www.inwmml.org.au or Inner North West Primary Care Partnership www.inwpcp.org.au*
Appendix 2: Inter-Agency Agreement

Inner North West Diabetes Services Review Collaborative
Inter-Agency Agreement

Background:
Increasing prevalence of diabetes and related health complications, combined with growing service demands, were the impetus for Inner North West Primary Care Partnership (INW PCP) member agencies to agree to work together on developing a more coordinated approach to service delivery. Through the Inner North West Diabetes Services Review Collaborative Project, a diabetes pathway was developed with the aim that more people with type 2 diabetes will receive the right service, at the right time, in the right setting.

Purpose:
The purpose of this agreement is to outline an expression of commitment and agreed guiding principles for ongoing use of the Inner North West Adult Diabetes Referral Pathway developed through this project.

Agreement:
Agency representatives who have participated in the Inner North West Diabetes Services Review Collaborative Project are committed to improving service coordination for people with diabetes. It is recognised that the following guiding principles will support the implementation of and sustain the outcomes achieved through the project:

1. Collaboration & Integration
   1.1 Agency representatives will continue to support the professional links developed and strengthened through the Collaborative Project
   1.2 All agency representatives will work to embed the Inner North West Adult Diabetes Referral Pathway within their organisational processes and implement the pathway in service delivery

2. Making Referrals
   2.1 All agency representatives will consider the levels of care and referral triggers outlined in the inner North West Adult Diabetes Referral Pathway when referring to local diabetes services
   2.2 On receipt of a referral with insufficient information, consistent information (minimum data set) will be requested from the referrer

3. Redirecting Referrals
   3.1 When a diabetes referral is received that does not meet the criteria on the Inner North West Adult Diabetes Referral Pathway, the referral will be redirected to the appropriate services as guided by the pathway
   3.2 On redirecting a referral from a General Practice, a letter advising of the redirection will be sent to inform the General Practice
   3.3 On redirecting a referral to Community Health, a patient letter will be sent advising of the redirection and of the new service provider along with an Inner North West Community Health Diabetes Services Brochure

4. Receiving Referrals
   4.1 Upon receipt of a redirected referral, the receiving agency will return a referral acknowledgement to the sender

5. Sustainability
   5.1 Participating agency representatives will meet bi-annually to review and update the Inner North West Adult Diabetes Referral Pathway and supporting resources
   5.2 The INW PCP will hold and maintain the soft copy of the Inner North West Community Health Diabetes Services Brochure and the Diabetes Pathway, in conjunction with participating agencies
   5.3 All agency representatives will promote the Inner North West Adult Diabetes Referral Pathway within their own organisation and amongst local professional networks
   5.4 Agency representatives leaving their current role will hand over the responsibilities for the Collaborative to an alternate representative from that agency
## Appendix 3: Stakeholder Analysis

**Stakeholder Analysis**
Anyone who can impact the project. Anyone who will be impacted by the Project.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Current Relationship</th>
<th>Desired Relationship</th>
<th>Interfaces</th>
<th>Key Messages</th>
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<td><strong>RMH Diabetes Education Unit</strong></td>
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<td>Community Collaborative Diabetes Demonstration</td>
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<td>Karina Walsh – CDE</td>
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</table>
Appendix 4: Project Logic Model

INWPCP Diabetes Services Collaborative Project November 2011—December 2012

Evaluation:
Focus, Collect Data, Analyse & Interpret, Report

Inputs → Activities → Outputs

Short-term benefits for participants immediately after project ends
Intermediate term benefits for participants 2-3 years after project completion
Long-term benefits for permanent years after the projects

Shared understanding of local system and practice changes required for improved continuity of care for people with Type 2 Diabetes
Local GPs will have increased awareness of Type 2 Diabetes referral pathways
Greater consistency in referral processes including referral acknowledgement
Greater collaboration improvement activity between local diabetes services

Intermediate outcomes:
- Improved understanding of local referral patterns for Type 2 Diabetes
- Greater partnership between local diabetes services

Outputs:
- Project Report
- Project Poster and吝定模型
- Project Logic Model Presentation

Contextual factors:
1. Time constraints of Working Group members will require awareness to have capacity for flexibility
2. It is likely that some aspects of the service system will not be amenable to change by the project’s improvement activities.

Assumptions:
A collaborative approach to this services coordination improvement initiative will achieve greater and more sustainable improvement than independent activity alone.