

Diabetes Education: The Success and Challenges in a remote location



Diabetes Services

Alice Springs Hospital

October 2015

Department of **Health** is a Smoke Free Workplace

Central Australian Aboriginal Communities



The Challenge

“The shortage of GPs in rural and remote Australia has led to a lack of continuity in the medical supervision of patients with diabetes, resulting in poor outcomes...”

“...the essential ingredient for a successful nurse led diabetes program is the right nurse with highly developed clinical and chronic disease self-management support skills in whom patients and GPs have confidence...allows for the vital collaborative relationships to develop...”

The Chronic Care Model

Emphasis on **self-management** to:

1. Change patients from passive to active
2. To encourage health professionals to be more proactive in changing patient behaviour.
 - With a focus on the Social Determinants of Health (SDoH) as a key action area.
 - Continuity of care, education and support
 - Individualised delivery of education

- There are 5 areas in which we operate:
 1. Community awareness and risk factor reduction for the prevention of diabetes
 2. Prevention and early diagnosis in high-risk groups
 3. Optimal evidence-based management
 4. Detection and management of complications
 5. Coordinated care for people with Chronic Conditions

Diabetes Education in Alice Springs Hospital: The acute care setting

- Where is the patient from?
- Reason for admission?
- Chronic disease profile
- Most recent HbA1c
- Diabetes management variance and why:
 - acute setting vs community setting
- Pathology
- Patient self-management education

Diabetes Education in ASH

Central Australian Health Service: ASH Diabetes (DM) Education

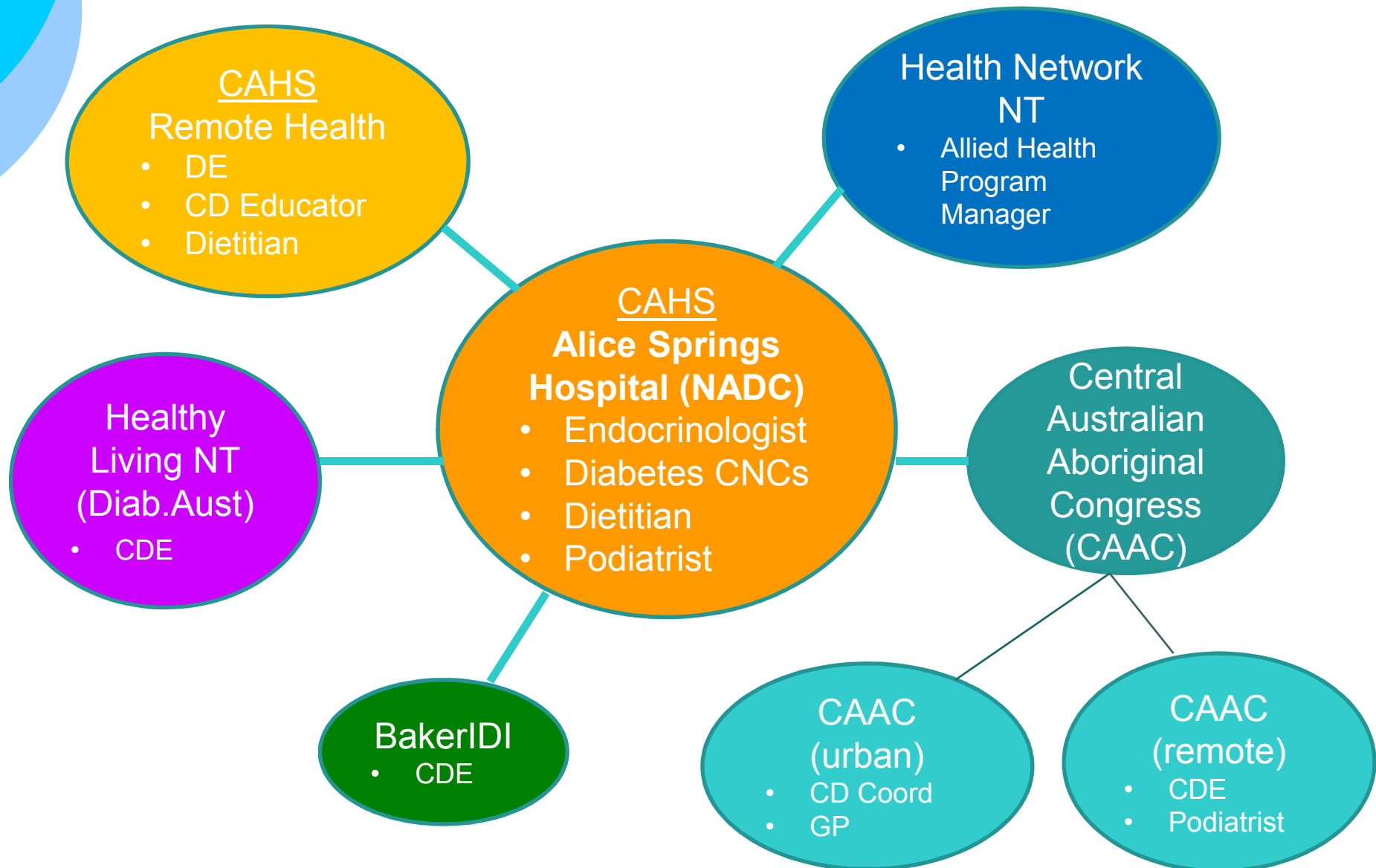
<u>Education Topic</u>	<u>Topic Explanation</u>
1. What is & Complications of DM: Yes <input type="checkbox"/> No <input type="checkbox"/> Demonstrates knowledge: Yes <input type="checkbox"/> No <input type="checkbox"/> Requires Reinforcement: Yes <input type="checkbox"/> No <input type="checkbox"/> Written/pictorial resources given: Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>What is & Complications of Diabetes</i> <i>"Diabetes 'no painin'; high 'sugar' eats away & makes sick on the inside (linked to complications). Lower sugar helps you to Stay Stronger on the Inside for longer"</i>
2. Target Glycaemic Range: Yes <input type="checkbox"/> No <input type="checkbox"/> Visual aid used: Yes <input type="checkbox"/> No <input type="checkbox"/>	Target Glycaemic Range <i>BGL Profile Chart used as visual aid. Linked to Topic 1</i>
3. Oral Medications: Yes <input type="checkbox"/> No <input type="checkbox"/> Able to choose usual OHAs: Yes <input type="checkbox"/> No <input type="checkbox"/> Takes daily: Yes <input type="checkbox"/> No <input type="checkbox"/> Demonstrates knowledge of: Dose: Yes <input type="checkbox"/> No <input type="checkbox"/> Timing: Yes <input type="checkbox"/> No <input type="checkbox"/>	Oral Hypoglycaemic Agents – OHAs <i>Education provided on: 1. How they work in the body <input type="checkbox"/>; 2. Possible side-effects <input type="checkbox"/>; 3. When & How to take. <input type="checkbox"/></i> Pt uses a dosette Box / Webster Pack <input type="checkbox"/> (possible reason Pt not able to choose usual OHAs)
4. HbA1c: Yes <input type="checkbox"/> No <input type="checkbox"/> Demonstrates knowledge: Yes <input type="checkbox"/> No <input type="checkbox"/> Visual aid used: Yes <input type="checkbox"/> No <input type="checkbox"/> Pictorial resources given: Yes <input type="checkbox"/> No <input type="checkbox"/>	HbA1c <i>HbA1c Indicator Chart used as visual aid. Education provided on: current HbA1c & Target value</i>
5. Healthy Eating & Lifestyle Modifications Yes <input type="checkbox"/> No <input type="checkbox"/> Demonstrates knowledge: Yes <input type="checkbox"/> No <input type="checkbox"/> Written/pictorial resources given: Yes <input type="checkbox"/> No <input type="checkbox"/>	Healthy Eating & Lifestyle Modifications <i>Education provided on: 1. How food affects BGLs <input type="checkbox"/>; 2. Portion sizes <input type="checkbox"/>; 3. Physical activity <input type="checkbox"/></i>

Signature + print

A patient-centered approach

- Engaging the patient in decision making and management of their illness, including setting appropriate goals
- Using evidence based, planned care
- Improving patient self management support
 - Enlisting other health professionals and supports;
 - Better linkages with community resources;
- A team approach to managing care

Central Australian Health Service (CAHS) The Diabetes Multi-disciplinary team



Diabetes Education: Challenges to successes

SUCCESS	CHALLENGES
NADC audits	Audit feedback to outside stakeholders. With discussions of 'where to and how'
Multidisciplinary collaboration	Collaboration with relevant stakeholders for 1. optimal effectiveness of specialist outreach services; 2. Optimal evidence-based diabetes management; 3. Continuity of support from the inpatient to the outpatient setting.
SDoH identified as a key action area that impacts on health outcomes.	SDoH (access, food security, education, addiction, stress, social support/cohesion, low income;
Education material, written & DVDs that is language and cultural specific	Cultural & language appropriate patient education material; e.g. pictorial vs written
Commitment of health professionals	Few in number to provide optimal, ongoing education & support Time poor in education delivery in the acute setting;
Referrals for patient follow-ups at discharge for remote community education and review	Highly mobile population group; Diabetes educators few in the remote setting

In summary:

- Remote Aboriginal communities have an increased burden of chronic disease.
- Requires more effective management to reduce the growing presentations of the acute management of chronic conditions.
- The Social Determinants of Health influence peoples health outcomes and self management.
- Support of self management practices while acknowledging the barriers.

References

1. Kirby S, Moore M, McGarron T, Johnstone P, Perkins D, Lyle D. 'People living in remote communities can have best-practice diabetes care'. *Rural and Remote Health* **15: 3203**. (Online) 2015.
Available: <http://www.rrh.org.au>
2. 'An Overview of the Chronic Care Model'
cited in: <https://cahps.ahrq.gov/quality-improvement/improvement-guide/browse-interventions/Communication/Planned-Visits/Chronic-Care-Model.html>
3. NT DoH. 2009. The Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020. Chronic Conditions Strategy Unit, Darwin.