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The CCHS Diabetes Service:

Catching people falling through the cracks: Using a inter-disciplinary team approach

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Aim of project:

- Increase access to interdisciplinary primary care services for clients with type 2 diabetes

- Optimise client's skills and confidence to self - manage

Method:

1

Establishment of CCHS Type 2 Diabetes inter-disciplinary team

- Credentialed Diabetes Nurse Educator (CDNE)
- Dietitian
- Exercise Physiologist (EP)

CDNE DIET EP CLIENT

2

Initial Assessment: Baseline

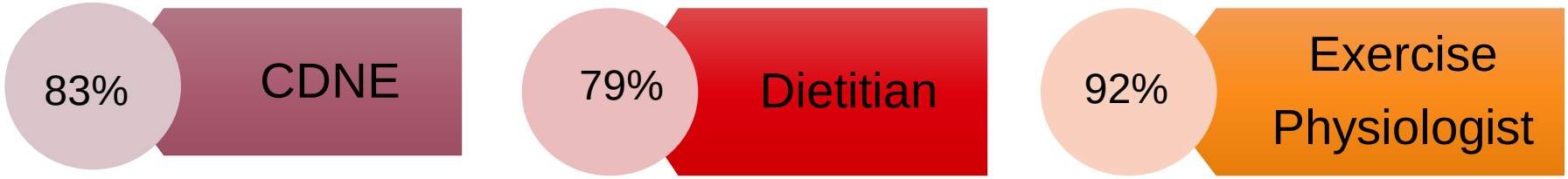
- Comprehensive joint assessment & care planning
- Prior attendance to community diabetes services ?
- Problem Areas In Diabetes (PAID)
- Self-Efficacy for Diabetes (SED)
- **Individualised program**

3

Client: 3 month team review

Results:

- Majority of clients had no prior community access to diabetes services



X A lack of clear goals for diabetes care (PAID)

X Worrying about the future & possibility of serious diabetes complications (PAID)

X Least confident in ability to exercise regularly (SED)

Results: 3 month review

- ✓Clear goals for diabetes care (PAID)
- ✓Feeling more encouraged with management plan (PAID)
- ✓Confidence improved in all areas (SED)

- Confidence in managing blood glucose levels

- Ability to exercise regularly and manage blood glucose levels

- Knowing when to see the doctor for diabetes related issues

Client Satisfaction	Net promoter score of 85
Referrer Satisfaction	Net promoter score of 68

"..**most positive diabetes related experience** since being diagnosed with diabetes 30 years ago"

"**The team were a massive help** and I walked away feeling a million dollars better!"

"I have **started exercising!**"

"I feel **empowered**"

"**My fridge has changed! More fruit and vegetables**".

"Feel **more positive** and feel like **I can manage my diabetes** which I didn't feel before"

"I learned a lot about diet, exercise and monitoring blood sugar levels"

"In a **better place to make decisions about my health** as I am better informed"

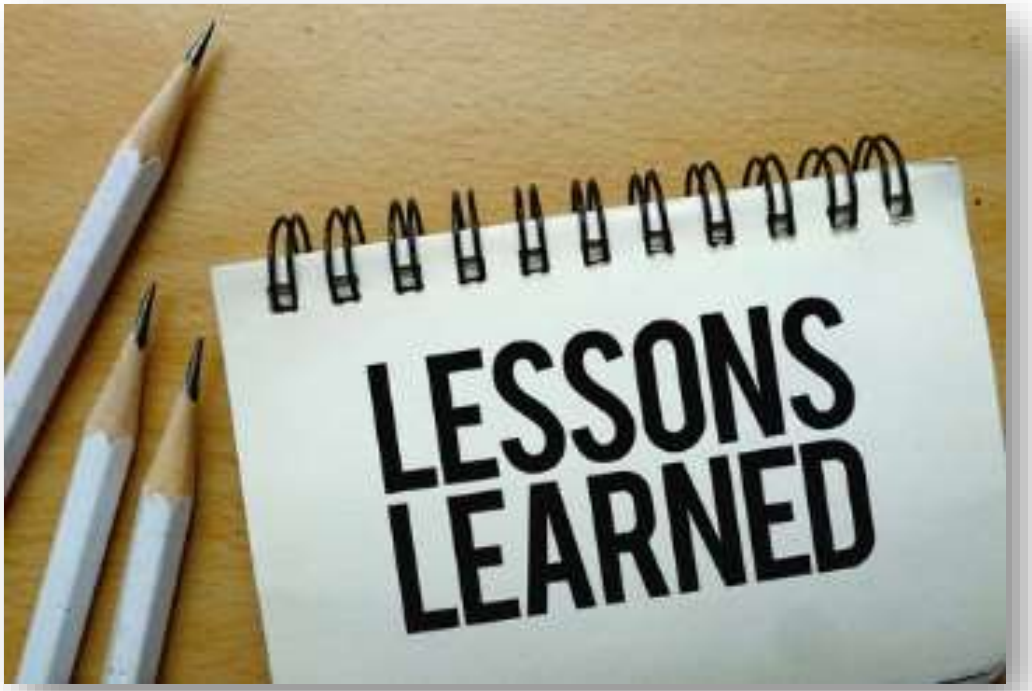
Challenges & Barriers:

- Marketing service to GP's
- Interest in group education & group exercise classes
- Small uptake of EP in the first 2 months of the program
- Completion of questionnaires (72%)

Learnings:

- Interdisciplinary assessment process
- Integration of an EP screening assessment at initial appointment

- GPs – cost, team approach, referral, CCHS allied health



Conclusion:

- Bridging the gap in the local community:
  by increasing access to primary care diabetes services

- Clients improving confidence to self-manage their diabetes after attending program

Outcome following pilot:

- Permanent ongoing funding of CCHS Type 2 Diabetes Service
- Annual review offered to all clients
- Use of SED Questionnaire to guide goals of diabetes management
- Strengthened interdisciplinary team communication and handover
- Increased awareness of service within GP's in the local area
- Introduction of web based self management tool (Nellie)

Acknowledgements:

CCHS Team

Consumer Engagement and participation team

Referrers

Clients