Danila Dilba
Health Service

# AMSANT CQI Collaborative Presentation

Planning a Diabetes service – ATSI Primary health service

**Cheryl Sanderson - Credentialled Diabetes Nurse Educator**
**Tues 21st June 2022 –** 1330 (15min presentation)

- *I would like to acknowledge the Larrakia people as the Traditional Owners of the Darwin region. I pay our respects to the Larrakia elders past and present.”*

    - *I am a visitor here – my traditional country and ancestors are from the Central Australian Arrernte Peoples.*

# PRIMARY HEALTH CARE AND CULTURAL SAFETY

Effective primary health care can help avoid unnecessary hospitalisations and improve health outcomes (AMA 2017; OECD 2017).

Cultural safety is **defined by the consumer** accessing care, and they must be involved in decision-making about how their care is delivered.

Cultural safety, at an individual level, addresses the **power imbalance** between the health practitioner and the consumer.

Culturally safe practice involves practitioners acknowledging how **their own beliefs and biases** can influence their practice and the way that consumers receive care.

Cultural safety | RANZCP

# National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care

Government-funded Aboriginal Medical Services report a set of 21 Aboriginal and Torres Strait Islander National Key Performance Indicators (nKPIs) Data is used to measure progress towards the Closing the Gap health outcomes of Aboriginal and Torres Strait Islander people.

•**PI05**: Proportion of regular clients who are Indigenous, have Type II diabetes who have had an **HbA1c measurement** result recorded within the previous **six months** and proportion of regular clients who are Indigenous, have Type II diabetes and who have had an HbA1c measurement result recorded within the previous 12 months

•**PI06**: Proportion of regular clients who are Indigenous, have Type II diabetes and whose **HbA1c measurement** result, recorded within either the previous six months or 12 months, was categorised as one of the following:

- less than or equal to 7% (less than or equal to 53 mmol/mol); ^
- greater than 7% but less than or equal to 8% (greater than 53 mmol/mol but less than or equal to 64 mmol/mol); ^
- greater than 8% but less than 10% (greater than 64 mmol/mol but less than 86 mmol/mol); ^ or
- greater than or equal to 10% (greater than or equal to 86 mmol/mol). ^

•**PI18**: Proportion of regular clients who are Indigenous, aged 15 years and over who are recorded as having Type II diabetes and have had an estimated glomerular filtration rate **(eGFR) recorded AND/OR an albumin/creatinine ration (ACR)** or other micro albumin test result recorded within the previous 12 months.

•**PI19**: Number and proportion of Indigenous regular clients with Type 2 Diabetes and/or Cardiovascular Disease (CVD) who had **both an eGFR and ACR result** recorded within the last 12 months.

•**PI23:** Proportion of regular clients who are Indigenous, have Type II diabetes and who have had a **blood pressure measurement** result recorded within the previous 6 months.

•**PI24:** Proportion of regular clients who are Indigenous, have Type II diabetes and whose **blood pressure measurement** result, recorded within the previous 6 months, was less than or equal to 140/90 mmHg.

# Danila Dilba Diabetes Service

Active Mob team – Allied health service – Diabetes Educator, Dietitian, Podiatry and Physiotherapy.

- DE Service 6 clinics- Knuckey St, Malak, Rapid Creek, Bagot and Palmerston, Humpty Doo,+ Mens clinic (RDH visiting Endocrinologist)
- RDH Endocrinologist Specialist clinic monthly

*Providing ADEA MENTORING support to others in the process or thinking of Specialising and Credentialling*

# Challenges – finding my way

- 7 Different clinics; Finding my way & getting lost in the big city.
- Scheduling weekly timetable – negotiating with Clinic managers
- Endocrinology clinic planning, referrals/followup
- Clinic Room availability – preferably close to Dietitian.
- General staff turnover
- Referrals from GP's – getting through the backlog

- COVID pandemic – PPE, Telehealth

# Primary health care - Diabetes service at Danila Dilba

Type 1, Type 2, GDM, Diabetes of the pancreas, MODY (genetic), Young persons with Diabetes (and Mixed)…

- Follow “RACGP Management of type 2 diabetes: A handbook for general practice, Type 2 diabetes: Goals for optimum management
- Diabetes Cycle of care (SNAPE, Dental, Optometry, Podiatry, SEWB, Drivers license, Immunisations etc)

Facilitating Care planning, Reviews and Annual Health checks and linking in to DDHS clinics for timely care for Prevention of illness and promotion of health.

# …Cont Diabetes service at Danila Dilba

- New Diagnosis of Diabetes
- Recent hospital Admission
- Pre- conception
- Gestational Diabetes – the DDHS midwives are outstanding !

- Glucose monitoring and other Technology CGM such as Libre2
- Medications support Insulin management, GLP- 1 weekly medication start, Oral medications

- Support Management of diabetes by Care services.

# Collaboration and capacity build

Work with GP's and facilitating the completion of the Allied referral letter and developing an Allied health pathways document

Team work – GP'/RN's/AHP's/Care coordinators/Midwives/Transport drivers/IOW's/ CSO's

RDH Endocrinology specialist services including the Palmerston Hospital Weight Management Clinic

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# What has worked really well?

Collaboration with Dietitian – Bernadeen Gibb – mostly linked our clinic days and booked patients together across clinics.  Case discussions with GP's to improve management and care. Booking followups to align Dietetic/Diabetes educator services.

*Recent collaboration with DDHS Pharmacist  – Hazel to support ADEA credentialling hours. Shadow diabetes clinics and continue with own appts for Diabetes medication education/reviews/glucose monitoring/start insulin/start injectables. Diabetes Annual cycle of care.*

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# Quality improvements for Diabetes

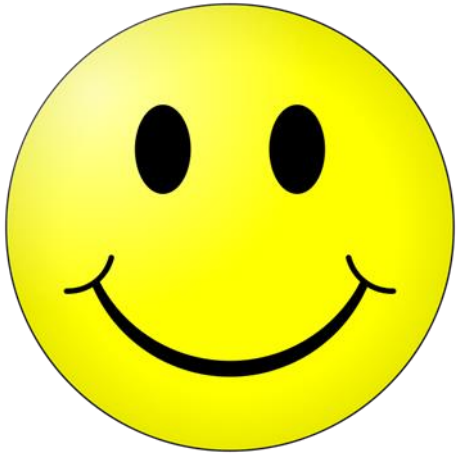
Patient information record system (PIRS) – COMMUNICARE

- Use data reporting to prioritise patients and plan care & followup
- Promote the Diabetes cycle of care – for planned timely care

Promote Hba1c point of care – QAAMS – clinicians education training and use of the Hba1c.

Building support for AHP's – currently working on a trial with ADEA to create pathways for AHP's to complete Diabetes Educator University education.

# Thank you !



# REFERERENCES


RACGP - Type 2 diabetes: Goals for optimum management

Enablers and Barriers to Accessing Healthcare Services for Aboriginal People in New South Wales, Australia - PMC (nih.gov)

Cultural safety | RANZCP

Primary health care - Australian Institute of Health and Welfare (aihw.gov.au)

National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care | Australian Government Department of Health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