DIABETES: living better & stronger

Care Partnership Diabetes

# Accelerating our move towards **Value Based Healthcare**

## A Framework for Collaborative Commissioning in Western NSW

NSW GOVERNMENT

phn WESTERN NSW
An Australian Government Initiative

NSW Rural Doctors Network
CELEBRATING 35 YEARS

**We acknowledge the traditional owners of the Country throughout Western NSW, and their continuing connection to land and community. We pay our respect to traditional owners, to Elders both past and present and acknowledge the privilege we have to live and work on Aboriginal lands. We share and celebrate the rich history of Aboriginal culture and recognise the diverse and proud Aboriginal nations across our District.**

**We are committed to improving Aboriginal health and the health outcomes and experiences for all people and all communities across our region. We all contribute to making a difference in health outcomes and have a responsibility to make a real and lasting difference in the lives of all people living in Western NSW.**

The Aboriginal Motif used in this publication/ pictured was created by Lewis Burns for WNSW PHN.

The row of dots represents a river, large dots in the centre represents stronger flowing water in the centre of the river and smaller dots alongside represent the slower flow on the river's edge.

The "U" shaped symbols with the dot between them above the river represent people sitting at camps or at campfires along the river. The other random dots represent the ground or the earth or "Country" where people would hunt & gather, or "Country" that people respected and would care for.

Holistically the story represents a healthy lifestyle with fresh clean water and abundant natural foods while living off the land.

***– Lewis Burns (Artist)***

# Contents

# The Framework

**Care Partnership – Diabetes is about working together for one health system.**

**Focus:**
People living with Type 2 Diabetes (T2DM), diagnosed and undiagnosed, who have HbA1c above 7% mmol/L

**Scope of work**

- ✓ Screening
- ✓ Early interventions across priority populations
- ✓ Clinical management and enabling patients to improve self-management

Incorporates the **Quadruple Aim** to deliver Value-based Healthcare


**Principles:**

- A one health system mindset
- Working together
- Planning and evaluating
- A regional focus
- Workforce supports

## OUTPUTS

Output indicators will describe the **actions undertaken** to achieve goals.

## OUTCOMES

Outcome indicators will measure **whether the goals were achieved.**

### SYSTEM CHANGE

The Care Partnership – Diabetes **program work** focuses on the system level. This aims to achieve system-level improvements that can then flow through to longer-term service improvements and patient outcomes.

**What we will do:**

- Build collaboration between health services and communities.
- Build consensus around models of care delivery that are grounded in a one health system mindset.
- Build capacity of local health services to jointly deliver high quality, integrated care to people with T2DM.

### SERVICE DELIVERY

The service delivery focus is on delivering high quality, integrated patient care, particularly for priority populations. This will be delivered by the collaborating local services, supported by the program work.

**What we will do:**

- Increase earlier identification of undiagnosed T2DM.
- Increase the engagement of people with T2DM with a GP or other primary care provider.
- Improve routine health care and self-management of T2DM.
- Improve escalated care for patients with complex or high care needs.

### SYSTEM OUTCOMES

- The health system is more effective, efficient and sustainable in providing care for people living with T2DM.
- There are improvements in key indicators relevant to each service delivery setting, such as reducing potentially preventable hospitalisations.
- The experience of providing care to people with T2DM care is improved.

### PATIENT OUTCOMES

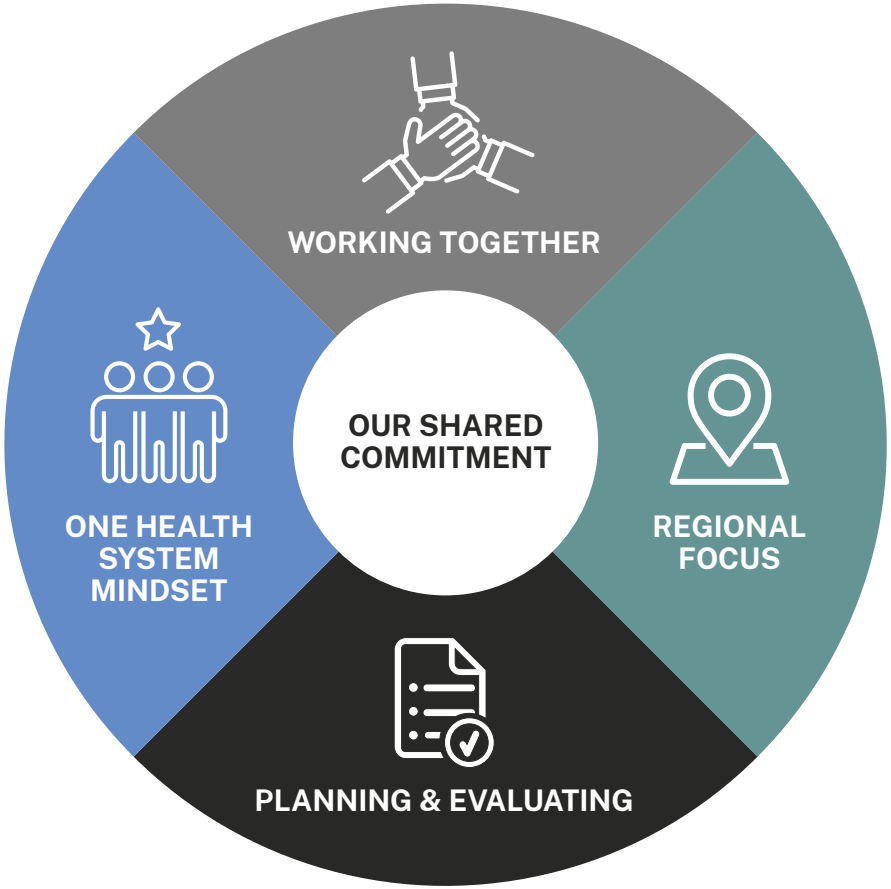
- More people with previously undiagnosed T2DM are identified.
- More people with T2DM are engaged with a GP/primary care provider at the centre of their ongoing care.
- Outcomes for people with T2DM are improved, including for those from our priority populations.
- Patient and carer experiences of care are improved.

# A context for action

## A joint commitment to system reform

NSW Health, the NSW Primary Health Networks and the Primary Care Division of the Australian Government Department of Health recently released a joint statement of intent to reflect the growing need for work of this kind to be done at the system level. Working together to deliver person-centred healthcare[1] recognises that our health system is complex, and that, despite many ongoing efforts, it remains disjointed in many ways. Patient-centred care requires better collaboration to integrate the care delivered across primary, acute and community settings. Evidence shows that when systems collaborate more effectively, outcomes are improved1. This requires:

- A **one health system mindset** which supports us to think and act beyond our current structures and boundaries in healthcare.
- **Working together** with shared principles and shared focus areas to address shared challenges and build capacity in workforce and systems.
- **Planning and evaluating** our actions to improve healthcare experiences, population health outcomes and health system cost efficiency.
- **A regional focus** for planning, commissioning, designing and delivering healthcare backed by the right system support from the State and the Commonwealth[1].




## Collaborative Commissioning

Collaborative Commissioning[2, 3] is one of the practical investments being made to achieve this system transformation. It represents an autonomous and jointly accountable partnership between the PHN, RDN and LHDs. It is intended to signal a significant commitment to a new way of doing business: one in which our primary focus is on value rather than volume. The whole-of-system approach will include:

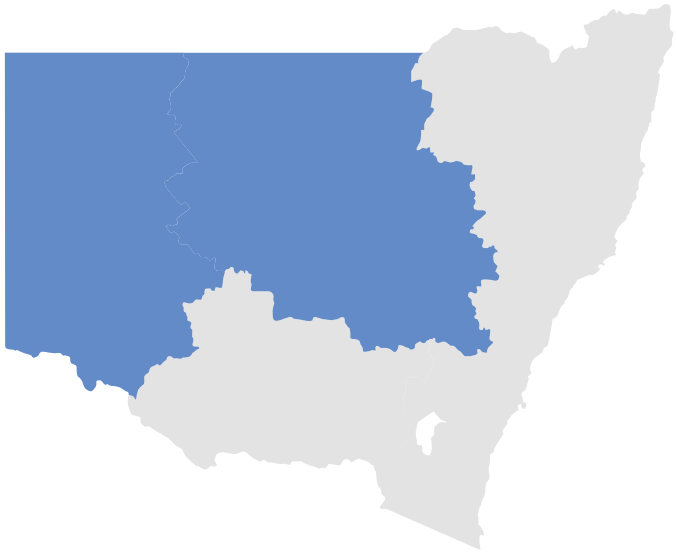
- Commissioned care pathways that are designed to address local needs and create greater integration of care.
- Opportunities to strategically deploy existing resources and embed them into integrated care pathways.
- An innovative funding and payment model to support Value Based Healthcare in the community and outcomes-based funding for achievement of targets.

Collaborative Commissioning is an example of Value Based Healthcare[4] across NSW. This work is underpinned by the **Quadruple Aim**[5] which acknowledges that there are multiple elements within the concept of "value", all of which are important. At the system level, this includes efficiency and effectiveness as well as the experience of clinicians and other health professionals. At the patient level, this includes better patient outcomes and the experience of patients, carers and families.

## A local partnership

Care Partnership – Diabetes is a partnership between Far West Local Health District (LHD), Western NSW LHD, Western NSW Primary Health Network (WNSW PHN) and the NSW Rural Doctors Network. The work will be done across the geographic footprints of the two LHDs.

We acknowledge the traditional owners of the Country throughout Western NSW, and their continuing connection to land and community. We pay our respect to traditional owners, to Elders both past and present and acknowledge the privilege we have to live and work on Aboriginal lands.



**Over 310,000**
people including
**40,000**
**Aboriginal people**

**Over 400,000km²**
**covering over 50% of NSW:**
geographically the largest PHN in NSW and the two largest LHDS in NSW

A mixture of hospitals, multipurpose services and community-based services

**Over 400**
general practitioners working in
**over 100**
General Practices including Aboriginal Medical Services

## A local priority for action

T2DM has been selected as the focus for this action due to its high prevalence, significant implications for health and wellbeing, and the potential for marked improvements in coordinated and integrated care across our region. Type 1 Diabetes and Gestational Diabetes are not the specific focus of the program, though they may have some tangential relevance to/benefits from some aspects of this work.

T2DM is a prominent public health challenge. Almost 1 million Australians have T2DM[6]. Evidence suggests that this is underreported and that for every four diagnosed adults, there is potentially one more who is undiagnosed[6].

Aboriginal Australians, those from a background of socioeconomic disadvantage and those living in remote and very remote areas are all disproportionately impacted by T2DM[6], making this a high priority for our region[7-10].

Consultation undertaken to inform the process thus far has identified a range of system-level challenges that compound this further. This includes but is not limited to service and workforce capacity, fragmented service planning, and the logistical challenges of delivering services in remote areas. The myriad of complex issues and potential solutions underline the importance of taking a strategic, system-level approach.

**1 in 20**

**people in the region have T2DM**

**18,400**

**people with T2DM registered with the National Diabetes Service Scheme**

**4,500 or more?**

**additional undiagnosed cases of T2DM across our region**

Prevalence statistics from the National Diabetes Service Scheme (NDSS) Australian Diabetes Map, accessed Nov 2021. Potentially undiagnosed estimates based on AIHW national estimates and applied to NDDS data.

## Co-production

Care Partnership – Diabetes will continue to be co-produced in partnership with regional and local stakeholders. This will include partnering with GP practices, Aboriginal Community Controlled Health Services and others who have local knowledge that is integral to the design and implementation of services that will be accessed by communities.

The program's initial co-design process included stakeholder consultation, workshops and design sessions. This will be built upon through the program's ongoing co-production in partnership with stakeholders.

Initial reflections have identified and included processes for:

- The vision for a targeted and patient-centred model of care
- Exploration of regional characteristics and key focus areas for discussion
- Identification of the ideal elements of future patient pathways
- Discussion of critical barriers and pain points experienced by patients and providers, and how these might be overcome
- Development of a series of case study "personas" to model discussions around, to ensure a grounded, real-world perspective on this work.

Leadership was provided by Far West Local Health LHD, Western NSW LHD, WNSW PHN and the NSW Rural Doctors Network. Input to the program's co-production has and will continue to include:

- People living with T2DM
- Carers of people living with T2DM
- Aboriginal staff in partner agencies
- Aboriginal Community Controlled Health Services
- Academics and researchers
- Diabetes educators
- Diabetes program managers
- Epidemiologists and data analysts
- General Practitioners (GPs)
- LHD Health Service Managers
- Managers and staff of local chronic and integrated care programs
- Nurse managers
- Pharmacists
- Staff specialists and geriatricians
- Allied Health Professionals

**Improved identification and local supports. This includes:**

- Enhance early identification of T2DM to permit early intervention, prevent potentially avoidable hospitalisations and reduce disease severity, particularly within priority populations such as Aboriginal communities.
- Understanding T2DM hereditary susceptibility for Aboriginal people and impact on culture
- Supporting the non-medical workforce to engage with community

Support effective place-based community engagement, driving awareness around diabetes generally and the importance of testing. **Enhanced ongoing management of diabetes and secondary complexities in primary and acute care. This includes:**

- Integrate through shared patient responsibility resulting in increased abilities and capacity, at all levels, to manage diabetes, prevent unnecessary and common secondary complexities, and prevent unnecessary escalation where possible.
- Boost patient and community health literacy encouraging patient-empowerment and control over their diabetes.
- Ensure patients and healthcare providers are connected with one another and relevant supports.
- Support the health workforce whole-of-person capability with resources, skills, networks to provide quality care for people living with T2DM.
- Leverage technology to overcome barriers relating to geographic isolation.
- Foster shared care and collaborative ways of working to deliver pan-system, multidisciplinary, holistic and integrated care for patients (and their families/carers).
- A focus on culturally competent care.
- Engage in continuous quality improvement

**Streamlined hospitalisation and transfer of care. This includes:**

- Support primary and secondary care staff to work together, streamlining patient transitions.
- Ensure continuity of care by connecting patients with GPs in the community, reducing the likelihood of re-presentation to hospital.

## What is different about this work?

Many across our region are doing important work in this area. This includes but is not limited to the following services and programs.

- GP Practices
- Chronic Disease Management and Prevention Program (CDMPP)
- Leading Better Value Care: Inpatients Diabetes Mellitus
- Leading Better Value Care: Diabetes High Risk Foot Service
- Planned Care for Better Health
- Engagement with Aboriginal Community Controlled Health Organisations
- Collaborative Care
- Aboriginal Community Controlled Health Services
- Outreach Program services

These important investments are reshaping the service landscape. But that landscape remains fragmented and current funding models do not typically extend to addressing the higher order system issues. This program is designed to strengthen local foundations with a focus on the system level work.

**Care Partnership – Diabetes has been funded by NSW Government to put the "one health system mindset" into practice. It uses a consensus process to achieve common goals across the region. Further, it draws from pooled resources, which demonstrates the commitment of all the partners to providing the practical means necessary to achieve this, willingness to share the risk, and commitment to outcome achievement.**

The program will include work to improve systems in the following ways.

- **Increase collaboration** between health services and with communities.
- **Build consensus** around models of care delivery, with a strong focus on reaching those who need it the most.
- **Strengthen capacity** of local health services to deliver high quality, integrated care to people with T2DM.

## WHAT WE WILL DO

**Work at the system level:**

- **Collaboration**
- **Consensus**
- **Capacity**

**Support local services and programs to deliver high-quality, integrated care**

## WHAT WE HOPE TO ACHIEVE

**At the system level:**

- **Increased effectiveness, efficiency and sustainability**
- **Improved clinician experience**

**At the patient level:**

- **Better patient outcomes**
- **Improved patient experience**

Incorporates the **Quadruple Aim** to deliver Value-based Healthcare

## The complexities of diabetes care

| Some of the many regional complexities | | | |
|---|---|---|---|
| Inner regional | Outer regional | Remote | Very remote |
| Population 5,000 – | Population ~ 4,000 | Population ~ 1,000 | Population <500 |
| Reasonable internet and phone coverage | | Unreliable internet and phone coverage | |
| GP/ACCHS | Limited access / lengthy drive to GP/ACCHS | | |
| Local hospital | Local hospital | | Local hospital |

| The many complexities patients face | |
|---|---|
| Social isolation | Multiple medications |
| Distrust of the system | Not knowing how to engage |
| Socioeconomic disadvantage | Level of education |
| Kinship responsibilities | Level of health literacy |
| Aboriginal | Alcohol and other drug history |
| Non-English speaking | Unstable income |
| Disability | Many competing priorities |
| Role of carer | Not having regular GP |
| Early age diagnosis | Not trusting GP |
| Overweight | Co-occurring illnesses |
| Undiagnosed diabetes | |

## Kirra

My name is Kirra, I'm 65, and an Elder in my community. I get most of my medical help through the local Aboriginal Health Services. I don't have a car of my own so they help out with transport to Broken Hill when I need to see the doctor.

I don't like travelling because it means I am away from my great-grandchildren. I look after my four great-grandchildren and this makes it hard for me to seek help and care as often as I probably need it. I don't have the time and would need to leave them by themselves. It's really hard to find someone to take care of them when I am away.

When there is no other option I travel to Broken Hill, but it's hard to get an appointment and its usually with a different GP each visit, which is frustrating as I have to constantly re-explain my situation. If I need to see people at the hospital, appointments are sometimes spread out over the week, so I need to stay there for multiple days.

I know I have diabetes and high blood pressure, and recently have had really bad pain in my teeth so the GP in Broken Hill prescribed me pain killers. I haven't gone to the dentist yet as there are none in the area. I also have kidney problems and they keep telling me I will end up on one of those kidney machines which is making me depressed.

## Jeff

My name is Jeff. I'm 35. I live with two children and my wife, Carol, who has taken pretty good care of me ever since an accident that put me into a wheelchair. She has been my rock and whilst I try and be as independent as I can, I can see she is getting overwhelmed at times by caring for me without a break.

I was diagnosed with Type 2 diabetes when I was 33. Recently, I went to the hospital with chest pain and had to be transferred to Sydney for surgery.

Blood tests showed that my sugars were high. It's been hard to manage the new tablets and injections. Since leaving hospital I've been even more reliant on my wife, as she helps me with the new medications. It doesn't help that my regular GP has left, and I don't have a GP to contact so any problems that come up, I end up having to go to the Emergency Department.

The hospital said I need to book an appointment with a diabetes and endo specialist. It would be great if they had done that for me as I just haven't gotten around to it and not sure who to contact.

## Kylie

My name is Kylie, I'm 50 years old and run a successful vineyard. I'm a single mother of two adult children, but they're off doing their own thing now and are away from home, so I don't see them very often. My work schedule is very hectic, so I don't really have time to make friends in the community, nor do I have much time to exercise.

I've been going to the same GP, Matthew, for a while now. I really like him, and usually visit him every 6 months or so to go over my diabetes care plan and get a general check-up.

I was diagnosed with diabetes a few years ago and am now on 3 different tablets. I get frustrated as this doesn't seem to be working, but I know my weight and smoking has something to do with it. Matthew is helping me try to lose weight, and I know if I cannot there's likely to be serious complications for my health. I can tell that he gets frustrated when the weight doesn't drop but I don't think his recommendations are right for me and my body type. He has mentioned that he's going to try to get some specialist advice that might be able to help me.

## Diabetes in Aboriginal communities

National estimates[11] suggest that Aboriginal communities have:

- A higher prevalence of diabetes
- Higher rates of complications
- Onset and diagnosis at increasingly younger ages

This will require a long-term, coordinated response at many different levels. The consultation undertaken to inform this Framework included extensive discussions with Aboriginal health workers and community-controlled organisations. Issues raised included distrust of the system, the cultural competency of health services, having no regular contact with a general practitioner or other primary health care provider, and late presentation for diagnosis and care. Broader determinants of health from early age and continuing throughout life also include socio-economic disadvantage, poor health literacy, remoteness, food insecurity and a range of lifestyle factors that contribute both to the risk of developing diabetes and the likelihood of subsequent complications and poor health outcomes11, 12.

Like the persona case studies on the previous page, “Joe” (see right) is a fictional character developed as part of the intensive co-design processes. These personas highlight the barriers and challenges patients may experience within the current system and explore potential pathways to address them. More detail on each of these persona stories is available in a separate document.

### Joe

My name is Joe. I’m 45 and I was diagnosed with the sugars earlier this year but have apparently had it for a while. I’ve seen many family members suffer from the sugars, developing heart and kidney issues but I don’t really understand it.

I recently got an eye test that showed I had a problem (early retinopathy). There’s also something going on with my feet – the Doc told me I was developing something called peripheral neuropathy (recently developed small ulcer over the metatarsal head of his left foot). He said I needed to lose weight (BMI of 30) and need to stop drinking as much and stop smoking altogether. The pain in my left foot is getting worse, making it hard to work. I’ve also started to notice that it’s going a funny colour.

I don’t like going to the hospital as my father died of the sugars in the hospital. I didn’t think that the care was respectful or sensitive of my father and our Aboriginal culture. They also gave me a booklet which I didn’t find useful and didn’t think was relevant. When I get the chance, I always discharge myself from hospital early. I also do not have a regular GP.

Since my foot is getting worse, it’s harder for me to work, meaning I can’t bring in as much money as I used to. I live with my brother and two younger sisters who tend to rely on me for cash every now and then. I am worried that I won’t be able to help them out as much moving forward.

| Patient characteristics | Regional characteristics | Patient goals and strengths | Current barriers/ pain points | Potential care pathways |
|---|---|---|---|---|
| • Aboriginal<br>• Low health literacy<br>• Distrust of the system<br>• No usual GP | • Population ~ 4,000<br>• Reasonable internet/ phone<br>• Local hospital > 1 hour away<br>• Lengthy drive to GP/ACCHS | • Proud Aboriginal man<br>• Love of family and culture<br>• Strong connection to former football club<br>• Desire to receive treatment from someone that knows and respects Aboriginal culture | • Limited mobility (foot pain)<br>• Hesitant to engage with services due to past bad experiences<br>• Only one GP in area, long wait times | • Streamlined care to address immediate issues and needs<br>• Enhanced ongoing management including more regular care<br>• Patient education/ health literacy to empower and enable self-care |

# What we will do

## Vision

Care Partnership – Diabetes will work at the system level to improve collaboration, consensus and capacity to achieve a more integrated health service landscape and improve patient outcomes for people with T2DM in our region.

## Scope of work

Whilst we recognise the importance of primary prevention, that is not within the funded scope of this work. Care Partnership – Diabetes is funded to focus on the following:

- ✓ **Screening** to identify people who have T2DM but are undiagnosed.
- ✓ **Early interventions across priority populations** (see below).
- ✓ **Clinical management** and enabling patients to improve **self-management**.

## Focus

The focus for this work is people living with T2DM (diagnosed and undiagnosed) who have HbA1c above 7% mmol/L.

Priority populations include:

- Aboriginal people
- People from a background of socioeconomic disadvantage
- People from culturally and linguistically diverse backgrounds
- People with poor access to services, such as those in remote communities
- People who do not have a usual primary care provider
- People with chronic and persistent mental illness

## Principles underpinning the work

The principles from the joint statement Working together to deliver person-centred healthcare will drive this work: **A one health system mindset, working together, workforce supports, planning and evaluating our work and taking a regional focus**[1].

Our organisations seek to deliver care that is person-centred, culturally safe, holistic and encouraging of patient, family and carer participation. We aim to deliver this care as close to home as is practical and safe, in a well-coordinated manner that places the general practitioner/primary care provider at the centre of ongoing continuity of care.

Consultation undertaken to inform the process thus far identified the following additional principles to underpin this work.

- A culture of shared care will foster partnership and collaboration across a patient's multi-disciplinary team, improving handover of care and driving better outcomes.
- The model must be feasible and sustainable to ensure successful roll-out, targeting key service gaps and barriers instead of 're-inventing the wheel.'
- Data and evidence-based decision making will ensure the work done is fit-for-purpose and has a focus on ongoing quality improvement.
- Patients should be empowered and supported to structure their care around their identified specific needs.
- Patients must have the same access to and quality of care, regardless of their location.
- Patient comorbidities, complexities and other dimensions of health (cultural, spiritual, social, emotional) should be managed holistically.
- The health workforce should be supported with upskilling, resources, and collegiate networks that contribute to quality of care, purpose and the attractiveness of working in the region.

**REGIONAL GP Dr Ai-Vee Chua**

Central West GP, Dr Ai-Vee Chua, says the program represents a very real opportunity to really make a difference to people in Western NSW in terms of their diabetes care and health outcomes and the potential to influence the next generation, and the next and future generations to come.

> “It’s the first real thing I’ve been involved in where all the key health organisations have made a commitment to really working together towards shared health outcomes. This provides a vehicle for really making a difference for the people we look after. We have so many challenges in Western NSW we need to do something differently to really make the change to mean that our population, who are in a disadvantaged position compared to the rest of the state and many other parts of Australia, and that they will have the chance to be people who are well, and well in the sense of their physical health, as well as being well, extending to cultural, social and emotional wellbeing.”
>
> *– Dr Chua.*

# Unpacking the Framework:
## The system level work

## What is our vision at the system level?

- Better strategic communication, cooperation and coordination between local health care providers.
- Service landscape is easier for both providers and patients to navigate.
- Shared care planning is shaped by clear Care Pathways across primary, community and acute settings.
- System-based inequities in access to care are addressed through a range of strategies including increased use of virtual and remote service delivery options.
- Greater focus on early interventions that will reduce the system impact of potentially preventable complications of T2DM.
- Our commitment to equity is reflected in our strong focus on our priority populations, such as Aboriginal people and people living in remote communities.

## SYSTEM GOALS

1 **Make the health system more effective, efficient and sustainable in providing care for people living with T2DM.**

2 **Achieve improvements in key indicators relevant to each service delivery setting, such as reducing potentially preventable hospitalisations.**

3 **Improve health professionals' experience of providing T2DM care.**

## WHAT WE WILL DO AT THE SYSTEM LEVEL TO ACHIEVE THIS

**OBJECTIVE ONE – Increase collaboration between health services and communities.**

1.1 Provide transparent and agile governance and leadership to drive collaborative system reform.

1.2 Strengthen partnerships with key stakeholders, including health services, community organisations and people living with diabetes.

1.3 Facilitate processes to collect and share information and data more effectively.

1.4 Develop strategies for ongoing communication and collaboration to sustain these partnerships into the future.

**OBJECTIVE TWO – Build consensus around models of care delivery that are grounded in a "one health system mindset".**

2.1 Co-produce Care Pathways that reflect a "one health system mindset" including agreed local priorities, program principles and an approach to local service delivery that can be sustained.

2.2 Co-produce tailored strategies within each of the Care Pathways to improve outcomes for priority populations such as Aboriginal people and people living in remote communities.

2.3 Co-produce collaborative commissioning solutions for delivery of these Care Pathways.

**OBJECTIVE THREE – Strengthen capacity of local health services to deliver high quality, integrated care to people with T2DM.**

3.1 Develop (or identify/modify existing) strategies to build workforce competencies to deliver the Care Pathways sustainably.

3.2 Develop (or identify/modify existing) practice tools and other relevant resources to support clinical practice.

3.3 Develop an ongoing quality improvement cycle for the Care Pathways.

# Unpacking the Framework:
## The service level work

## What is our vision at the system level?

**People with T2DM:**

- Are diagnosed and receive assessment and care sooner, reducing their risk of future complications.
- Have a GP or other primary care provider at the centre of coordinated care.
- Have improved health literacy and are empowered and enabled to take an active role in managing their health.
- Have their treatment and risks assessed regularly and are escalated into appropriate care if needed, to reduce their risk of complication, then return to routine care.
- Are more satisfied with their receipt of optimal, culturally safe and holistic care across all settings.

## SERVICE GOALS

1 **Identify previously undiagnosed people with T2DM.**

2 **Improve the engagement of all people with T2DM with a GP/ primary care provider at the centre of their ongoing care.**

3 **Improve outcomes for people with T2DM, including for those from our priority populations.**

4 **Improve patients' and carers' experience of care.**

## WHAT WE WILL DO AT THE SERVICE LEVEL TO ACHIEVE THIS

**OBJECTIVE ONE – Increase earlier identification of undiagnosed T2DM.**

1.1 Increase screening for diabetes across a variety of community settings.

1.2 Increase screening in priority populations, such as Aboriginal people and people living in remote communities.

**OBJECTIVE TWO – Increase the engagement of all people with T2DM with a GP/primary health care provider.**

2.1 Build community engagement, awareness and health literacy around the importance of engaging with a regular care provider to provide continuity of care including regular health checks, care planning and ongoing management.

2.2 Explore innovative methods of improving access to GPs for people with T2DM, particularly in priority populations such as Aboriginal people and people living in remote communities.

**OBJECTIVE THREE – Improve routine health care and self-management of T2DM.**

3.1 Implement Care Pathways for the ongoing care for people with T2DM.

3.2 Implement strategies to improve the integration and coordination of care.

3.3 Implement strategies to support a systematic, continuous quality improvement cycle.

3.4 Implement strategies to encourage and enable people with diabetes to improve their self-management.

3.5 Increase and improve the use of virtual and digital solutions.

3.6 Implement strategies to ensure that services are culturally safe and will address barriers, issues and needs of our priority populations, such as Aboriginal people and people living in remote communities.

**OBJECTIVE FOUR – Improve escalated care for patients with complex or high care needs.**

4.1 Implement Care Pathways for care escalation including appropriate transition/de-escalation back to routine care.

4.2 Implement practical supports for complex or high needs care, including systematic, continuous quality management.

4.3 Establish or support high-risk services.

## Pathways to better care

**INCREASE EARLIER DIAGNOSIS**

**4,500 or more?**

Screening initiatives
Community awareness
Priority population focus

Plus people already diagnosed

**1 in 20**

**18,400**

## INCREASE ENGAGEMENT WITH A USUAL GP OR OTHER PRIMARY PROVIDER

Do people with T2DM have a usual primary health care provider?

Is there local access to a GP?

What are the alternatives if not?

**Engage with GPs and other providers**
**Priority population focus**

**Engage with GP practices, ACCHSs, other providers and health practitioners**

**Engage community directly**
**Intake, assessment, referral options**

## IMPROVE ROUTINE CARE

**Care Pathways**

- Integration and coordination of care
- Virtual and digital solutions
- Quality improvement cycles
- Health literacy and self-management
- How do we enable equitable access?
- Priority population focus
- Planned care cycle
- Diagnosis
- Development of plan
- Medical review
- Patient reported outcome measures
- Incentivised case conferencing
- Flexible, patient-and practice-centred
- Annual review

**Including referral as appropriate to specialist, educative, self-management and lifestyle options**

## ESCALATE IF NEEDED

**Care Pathways**

- Care Pathways
- Integration and coordination of care
- Improved escalated care for patients with complex/high care needs

**Goal is to identify and respond quickly to reduce complications**

**Then de-escalate back into ongoing routine care**

Made possible by **one health system** with better **Collaboration – Consensus – Capacity**

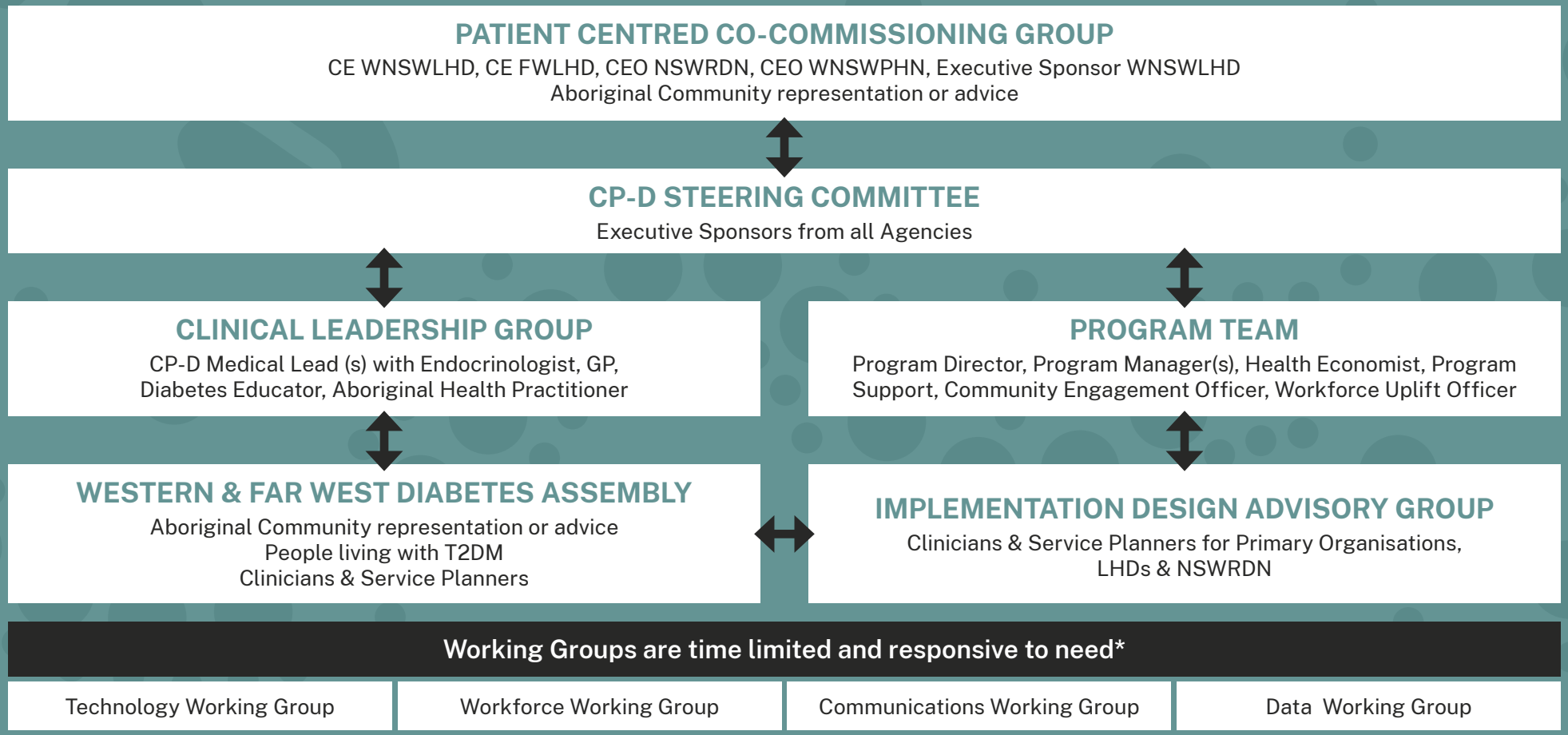
## Governance

Collaborative Commissioning work is overseen by a Patient Centred Co-commissioning Group (PCCG). This group has three core functions: governance, co-commissioning, and funding and payment. At this time, the group is focused on the Care Partnership – Diabetes work; in the future, the same governance model may be adapted to address other health issues.

The group is responsible for the following:

- Assessing and prioritising the needs of the population.
- Planning services to maximise use of local resources and minimise waste.
- Making strategic decisions on a whole-of-system basis, regardless of provider and setting.
- Co-commissioning appropriate healthcare services based on the local needs assessment, data analysis and regional prioritisation.
- Balancing high priority population needs, such as Aboriginal peoples and communities, while maintaining a longer-term focus on ensuring appropriate care across all populations.
- Monitoring delivery and outcomes of services and care pathways that fall within the scope of the PCCG.
- Informing stakeholders of performance and achievement of outcomes.
- Sharing the risk for financial sustainability underpinned by redesign of existing services.

The supporting governance structure (see above right) includes an Integrated Steering Committee, Diabetes Leadership Group and Implementation Design Advisory Group. These in turn are supported by working groups across a range of specialties.


PATIENT CENTRED CO-COMMISSIONING GROUP
CE WNSWLHD, CE FWLHD, CEO NSWRDN, CEO WNSWPHN, Executive Sponsor WNSWLHD
Aboriginal Community representation or advice
CP-D STEERING COMMITTEE
Executive Sponsors from all Agencies
CLINICAL LEADERSHIP GROUP
CP-D Medical Lead (s) with Endocrinologist, GP,
Diabetes Educator, Aboriginal Health Practitioner
PROGRAM TEAM
Program Director, Program Manager(s), Health Economist, Program
Support, Community Engagement Officer, Workforce Uplift Officer
WESTERN & FAR WEST DIABETES ASSEMBLY
Aboriginal Community representation or advice
People living with T2DM
Clinicians & Service Planners
IMPLEMENTATION DESIGN ADVISORY GROUP
Clinicians & Service Planners for Primary Organisations,
LHDs & NSWRDN
Working Groups are time limited and responsive to need*
Technology Working Group
Workforce Working Group
Communications Working Group
Data Working Group
* Others as required

## Building sustainability

An essential element of Care Partnership – Diabetes is the focus on sustainability. The system change focus requires a long-term view of not only what can be achieved, but how this can be maintained and sustained into the future. This includes consideration of the following key elements.

### FINANCIAL SUSTAINABILITY

Collaborative commissioning applies dynamic simulation modelling (DSM) to test the sustainability of the cost model in development phase.

It is the application of the DSM that provides confidence in ongoing value.

### COMMITMENT TO DELIVER

The PCCG contracts to the Ministry of Health to deliver:

agreed outcomes,

on time,

on budget.

### COMMISSIONING FOR OUTCOMES

Services commissioned will be accountable for the outcomes delivered for people living with T2DM underpinned by continuous improvement.

Shared responsibility builds a one health system mindset.

### BUSINESS AS USUAL

Planning and implementation focus on building the system change and service improvement to last.

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NSW GOVERNMENT

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CELEBRATING 35 YEARS

The Collaborative Commissioning Program is a collaboration between the Western NSW Local Health District, the Far West Local Health District, the Western NSW Primary Health Network, and the NSW Rural Doctors Network.

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Care Partnership Diabetes