DIABETES: living better & stronger | Care Partnership Diabetes

FACT SHEET

Supporting you and your patients with Type 2 Diabetes:

Information for General Practice & Aboriginal Community Controlled Health Services

Type 2 Diabetes Mellitus (T2DM) – the silent epidemic.

Diabetes prevalence in the Western and Far West NSW Region is 6.1% of the population, which is higher than the national average of 5.5%[1] and is increasing annually. T2DM is being diagnosed at younger ages, often presenting as a more advanced disease leading to comorbidities at a younger age. People in the region are 40% more likely to die as a result of their diabetes than the rest of NSW[2]. Our Indigenous population are at particular risk as 20% of people living with T2DM identify as Aboriginal.

We can turn it around by working together.

Working in the rural and remote primary health environment is both rewarding and challenging. We also recognise that there are gaps in access to and consistency of services that impact on patient care and outcomes.

This is why NSW is initiating a Collaborative Commissioning funding model for chronic disease to better support a more agile and responsive health sector across our regional footprint. Care Partnership – Diabetes is a collaboration between Western and Far West LHDs, RDN and WNSW PHN to work together to build on existing services and strengthen local pathways to enhance access to multidisciplinary diabetes care teams.

About Care Partnership – Diabetes

Care Partnership – Diabetes focuses on enhancing health outcomes for people living with T2DM living in Western and Far West NSW. We know that when detected earlier and when comprehensive and evidence-based care is provided, there is opportunity for remission and a reduction in the development of secondary complications.

Over the next three years, Care Partnership – Diabetes will work with you in a place-based rollout to support better:

1. **Engagement** of people and communities in understanding T2DM and making positive health changes
2. **Identification** of T2DM earlier through increased opportunities for screening and point-of-care testing
3. **Shared quality care** to improve communication and coordination between health care providers and patients, following an agreed T2DM pathway of care with improved access to specialist care
4. **Workforce uplift and engagement** to enhance health practitioner experiences of delivering care to people living with T2DM by increasing access to training, support and resources for the workforce.

Register your interest today to find out more and tailor a localised plan for your practice at **wnswphn.org.au/carepartnership-diabetes.**

[1] Western NSW Primary Health Network 2019, Health Profile, WNSW PHN Health Profile 2019 updated.pdf.
[2] Collaborative Commissioning for Diabetes in Western NSW National Diabetes Service Scheme 'Diabetes Map', https://map.ndss.com.au/#!/ (filtered by PHN and diabetes type).

Register your interest today at

wnswphn.org.au/carepartnership-diabetes

and a member of the Care Partnership – Diabetes will contact you to discuss further.

We can turn it around by working together

Care Partnership – Diabetes seeks to work with your practice to support patients with T2DM to achieve better health outcomes by improving:

- Timely identification of T2DM
- Access to diabetes-related services
- Communication between healthcare providers
- Patient understanding of diabetes
- Knowledge and skills of existing workforce

What does this mean for you?

Your patients living with T2DM and a HbA1c >7% will be able to:

- Have more timely access to diabetes-related services
- More opportunities for patient-facing education via variety of platforms

As a GP, you and your practice/ACCHS will have free access to:

- Locally relevant point of care T2DM guidelines, accessible via Western NSW Health Pathways
- Funding support for Practice Nurse/Aboriginal Health Practitioner hours focusing on T2DM
- A Western Diabetes Hub to assist with linking clinical services, education and mentoring opportunities
- Case conferencing with endocrinologists and other health providers
- Inca, a shared health record that permits patients' healthcare providers shared visibility of health conditions, medications, test results and management plans
- Patient Reported Measures using the Health Outcomes and Patient Experience (HOPE) system
- Education provided via ECHO (Enhanced Clinical Health Outcomes) learning sessions and Rural Health Pro
- NSW Health data about your patients, via an electronic platform called LUMOS

NSW GOVERNMENT

phn WESTERN NSW
An Australian Government Initiative

NSW Rural Doctors Network
CELEBRATING 30 YEARS

Register your interest at **wnswphn.org.au/carepartnership-diabetes** and a member of the CPD team will contact you to discuss further.

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.