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## APPENDICES

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Introduction

The Queensland Health Statewide Diabetes Clinical Network (SDCN) Forum was held at the Riverglenn Function Centre in Brisbane on Friday 18 May 2012. The Forum was facilitated by A/Prof Anthony Russell and Dr Trisha O’Moore-Sullivan, Clinical Co-chairs of the SDCN.

The objectives of the forum included:

- Providing an update on network activities
- Discussing topical changes and issues that impact upon delivery or improvement of diabetes services in Queensland.
- Discussing ideas to reduce preventable hospital admissions
- Considering planning priorities for the next six to twelve months and
- Encouraging networking.

Evaluation of the forum was extremely positive. Participants indicated their appreciation at being given the opportunity to network whilst receiving invaluable information to share with colleagues in their service.

This forum report can be obtained from the Statewide Diabetes Clinical Network website http://www.health.qld.gov.au/psq/networks/diabetes.asp. Presentation notes from the speakers are available on request by contacting clinical_networks@health.qld.gov.au. Please note that reading the speakers notes without having attended the forum to hear the presentation, may increase the risk of misinterpretation.

Forum Overview

The forum brought together 57 delegates with many of the Health Service Districts represented. The forum program included presentations delivered by clinicians from within the Network, as well as by partners from various government and non-government agencies.

Program Overview

Dr John Wakefield, PSM, Executive Director of Patient Safety & Quality Improvement Service, officially opened the forum.

SDCN Priorities and Understanding the Health Care Purchasing Framework

Associate Professor Anthony Russell briefly followed up on the 2011 November Forum paying particular attention to triage categorization, insulin pump checklist, diabetic foot education module, Chronic Disease Resources Online project completion, DKA protocols, Type 1 Diabetes Collaborative, diabetic educators and insulin titration and the completion of the Telephone Linked Care trial in rural and remote Queensland. Delegates were provided with a summary of the Health Care Purchasing Framework which would have been revision for many.
There was discussion about the future priorities of the network in the context of health reforms. The major priorities of the network for 2012 include:

- Reducing avoidable diabetes admissions by keeping patients healthy in the community
- Improving new to review ratios
- Completion of the Statewide Diabetes Services Planning Project with the assistance of Planning Branch, Queensland Health

**Funding Opportunities to Address the Network Priorities**

Dr Trisha O’Moore-Sullivan discussed recurrent funding available for the network from the previous Chronic Disease Program. This funding, in the order of $118k pa, had been previously used by the Telephone Linked Care project which has now been completed. The network will be accepting project proposals from the SDCN for use of this funding in the 2012/13 financial year. There is a relatively short time frame as these funds need to be allocated to a project as soon as possible. Details of this funding opportunity will be distributed to the SDCN by the network coordinator. Dr O’Moore-Sullivan reminded delegates that the key priorities of the network were outlined by A/Prof Anthony Russell.

**Diabetes Care Project**

Associate Professor Maarten Kamp, Endocrinologist, presented a recap of the Diabetes Care Project. Current progress across Australia was highlighted with a specific focus on Queensland achievements. The Diabetes Care Project pilot involves General Practices being randomized into one of two interventions group or a control group. The first intervention group includes provision of an Information Technology (IT) Tool for care coordination as well as training and capacity building. The second intervention group also involves provision of the IT Tool for care coordination as well as training and capacity building and also includes a new funding model. This funding model enables risk stratification and care coordination supported by a care facilitator, setting it apart from previous models. The pilot aims to recruit over 50 general practices in each group meaning that over 10,000 patients are expected to participate. At this point in time 147 practices have been enrolled.

**GP priorities**

Dr John Kastrissios, Chairman of the Greater Metro South Brisbane Medicare Local and Board Director of General Practice (GP) Queensland, presented on GP priorities. Dr Kastrissios made good use of the whiteboard, drawing diagrams representing the relationship between the patient, family, GP, allied health and surrounding health services. Dr Kastrissios believes that the health system to date is failing with the persistent creation of barriers between primary care and hospitals and specialists. He believes that GPs are systematically being deskillled over time. He illustrated his vision for the role of the Medicare Local as being responsible for ensuring good quality general practice and assisting with practice support, education and training. A particularly important role of the Medicare Local is identifying practices that may not be “practicing at the top of their licence”.

He outlined the role of a GP liaison officer to assist in transfer of care back from hospital health service to the general practitioner and also to ensure appropriate referrals into the hospital and private consultants. Dr Kastrissios also believes there is a greater role for specialists to provide telephone advice to primary care and for specialists to visit general practice.
Hospital in the Home
Dr Colin Kennett, Senior Medical Officer in Sub-acute Services from The Prince Charles Hospital spoke about the development and proposed future of ‘hospital in the home’ services offered in the Metro North district. Dr Kennett explored the differences between Home Based Acute Care Service (HBACS) and Hospital Avoidance Post Acute Care Service (HAPACS).

HBACS aims to provide acute treatment of a medical or surgical condition that would otherwise require hospital admission. Patients that may be suitable for HBACS include those requiring International Normalised Ratio (INR) stabilisation, intra-venous (IV) medications, treatment for infections, wound management and treatment of some respiratory conditions. Medical governance remains with the hospital staff.

HAPACS is a two week post hospital or emergency department discharge service that transfers medical governance to the GP. Suitable patients for HAPACS include those with issues of self care, those awaiting non-government services, those requiring medication via injection or catheter care and patients that frequently re-present to the emergency department following recent discharge.

Dr Kennett’s informative presentation provided delegates with an example of two services in existence within the home environment. These services tie in with the SDCN’s priorities of reducing hospital admissions by keeping patients well in the community.

Indigenous Health
Professor Ross Bailie from Northern Territory (NT) Department of Health spoke about supporting continuous quality improvement in primary health care. Professor Bailie discussed the ABCD (Audit & Best Practice for Chronic Disease) Continuous Quality Improvement (CQI) Project conducted in the Northern Territory from 2002 to 2006. The ABCD project is a multi level CQI project designed to support best practice in prevention and management of chronic disease in Indigenous primary health care.

Professor Bailie also discussed the One21seventy engagement strategy for quality improvement in Indigenous primary health centres. This strategy involved 188 health centres over 5 state/territory governments including Queensland. There were over 500 practitioners trained.

The Queensland results of the national diabetes audit tool were also presented. Professor Bailie demonstrated the changes between cycles in terms of current and complete management plans, influenza vaccination status, recording of key risk factors, recording and status of blood pressure and glycosylated haemoglobin (HbA1c) as well as various medication prescriptions.

Lessons from the South Australian Diabetes Network
Jane Giles, Manager of Diabetes Outreach in Country Health, South Australia (SA), presented an informative and interesting overview of the Country Health South Australia Diabetes Education Network. Ms Giles outlined the structure, function and membership of the SA network. At present the SA network
Prof David McIntyre (Chair of the Diabetes in Pregnancy WG) has representation from 11 clusters and Indigenous health. They have 20 members that have monthly teleconferences and a face to face meeting every year. The network is building the concept that there is one service operating on multiple sites.

Ms Giles’ presentation was valuable as delegates could compare the SA Diabetes Education Network with the SDCN. Of particular interest was the SA network’s website which was well set up and included many professional and consumer resources.

**HARP Model**

Dianne Berryman, Senior Project Officer from the Continuing Care Unit, Victorian Department of Health, spoke about the Hospital Admission Risk Program (HARP) in relation to diabetes services. HARP was defined as “collaboratively developing preventive models of care between acute and community providers targeting people with manifest health needs who are frequent users of the hospital system”. Established in 2001, the HARP program has grown to a total of 36 services covering rural, regional and metropolitan areas. Ms Berryman presented the seven key messages that arose from a review of HARP diabetes services. Like other presentations, Ms Berryman’s presentation tied in with the SDCN’s 2012 priorities of introducing services to keep patients well in the community and not requiring hospitalisation.

**Addressing Preventable Hospitalisations relating to the Diabetic Foot**

The chair of the Diabetic Foot Working Group, Ewan Kinnear, provided an entertaining presentation about how the Diabetic Foot Working Group is addressing preventable hospitalisations and reducing length of stay.

**Addressing Preventable Hospitalisations relating to Type 1 Diabetes**

Dr Trisha O’Moore-Sullivan and Dr Louise Conwell, co-chairs of the Type 1 Diabetes Working Group, explained that although this working group is a newly formed group, they have plans in the pipeline about ways to reduce hospital admissions. There is a particular focus on improving Diabetic Ketoacidosis management and developing strategies to help health professionals develop ‘sick day plans’ for their patients.
Addressing Preventable Hospitalisations relating to Diabetes in Pregnancy
Chair of the Diabetes in Pregnancy Working Group, Professor David McIntyre, spoke about the fact that avoidable admissions in pregnant women with diabetes are a rarity and regular visits with a health care professional are essential.

Group Discussion & Feedback
Delegates were invited to join one of three discussion groups which each addressed four questions. The discussion groups were in line with the SDCNs Working Groups and were made up of:
- Diabetic Foot
- Type 1 Diabetes
- Diabetes in Pregnancy

The questions as well as the responses that each group provided are outlined in Appendix 2

Close of Forum
On behalf of the Statewide Diabetes Clinical Network Steering Committee, Associate Professor Anthony Russell and Dr Trisha O'Moore-Sullivan thanked attendees for their participation in the 2012 Statewide Diabetes Clinical Network Forum. They also acknowledged the speakers whose support and participation contributed to the development of the agenda and enriched the forum proceedings.

Actions from the forum will be tabled at the next scheduled Steering Committee meeting for further consideration.

Evaluation
Of the 57 attendees, 56% submitted evaluation forms. Identified strengths of the forum lay predominantly in the program content, organisation, and networking opportunity. Opportunities to improve future forums included improved time keeping of speaker presentations, more time for work-shopping activities and a more centrally located venue. An overview of the responses from the evaluation forms can be found in Appendix 3.
## FORUM PROGRAM

### Friday 18 May 2012

9 am – 4.30 pm

*(Registration and coffee from 8.30 am)*

**Daintree Room, Riverglenn Function Centre**

70 Kate Street, Indooroopilly

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:30</td>
<td>Registration &amp; Coffee</td>
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</table>
| 9.00  | Welcome and Introduction  
**Dr Trisha O'Moore-Sullivan & A/Prof Anthony Russell, Co-chairs SDCN** |
| 9.05  | Opening of Forum  
**Dr John Wakefield, PSM, Executive Director, Patient Safety & Quality Improvement Service, CHI** |
| 9.15  | SDCN Priorities and Understanding the Health Care Purchasing Framework  
**A/Prof Anthony Russell, Co-chair SDCN** |
| 9.30  | Funding Opportunities to Address the Network Priorities  
**Dr Trisha O'Moore-Sullivan, Co-chair SDCN** |
| 9.40  | Diabetes Care Project  
**A/Prof Maarten Kamp, Endocrinologist, Metro North Health Service District.** |
| 10.00 | GP priorities  
**Dr John Kastrissios, Chairman Greater Metro South Brisbane Medicare Local & Board Director, General Practice Queensland** |
| 10.20 | Morning Tea                                                           |
| 10.40 | Hospital in the Home  
**Dr Colin Kennett, Senior Medical Officer, Subacute Services, The Prince Charles Hospital** |
| 11.05 | Indigenous Health  
**Prof Ross Bailie, NT Dept of Health** |
| 11.35 | Lessons from the South Australian Diabetes Network  
**Jane Giles, Manager, Diabetes Outreach, Country Health, SA** |
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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>12.05</td>
<td>HARP Model</td>
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<tr>
<td></td>
<td><em>Dianne Berryman, Senior Project Officer, Continuing Care Unit, Victorian Department of Health</em></td>
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<tr>
<td>12.35</td>
<td>Panel Discussion</td>
</tr>
<tr>
<td></td>
<td>• Issues for Diabetes Services</td>
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<td></td>
<td>• Prioritisation of Issues</td>
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<tr>
<td></td>
<td>• Potential Strategies to Address these Issues</td>
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<td>13.05</td>
<td>Lunch</td>
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<tr>
<td>13.50</td>
<td>Addressing Preventable Hospitalisations relating to the Diabetic Foot</td>
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<tr>
<td></td>
<td><em>Ewan Kinnear, Chair, Diabetic Foot Working Group</em></td>
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<tr>
<td>14:05</td>
<td>Addressing Preventable Hospitalisations relating to Type 1 Diabetes</td>
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<td></td>
<td><em>Dr Trisha O’Moore-Sullivan &amp; Dr Louise Conwell, Co-chairs, Type 1 Diabetes Working Group</em></td>
</tr>
<tr>
<td>14:20</td>
<td>Addressing Preventable Hospitalisations relating to Diabetes in Pregnancy</td>
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<tr>
<td></td>
<td><em>Prof David McIntyre, Chair, Diabetes in Pregnancy Working Group</em></td>
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<tr>
<td>14:35</td>
<td>Group Discussion</td>
</tr>
<tr>
<td>15.35</td>
<td>Afternoon Tea</td>
</tr>
<tr>
<td>15.55</td>
<td>Feed back from group discussion</td>
</tr>
<tr>
<td>16.25</td>
<td>Date for next Forum, Summation &amp; Close</td>
</tr>
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‘Working together to keep patients well in the community and prevent hospital admission’
Appendix 2

Feedback from Discussion Groups

Diabetic Foot Discussion Group

1. What are you currently doing that addresses the network’s priorities?
   • Coordination of care services (podiatry / CDE) to improve patient outcomes
   • Multidisciplinary community based patient support
   • Noted that there is a lack of services in rural and remote areas
   • Importance of early intervention
   • Have podiatry services visit general practice (based upon UK guidelines)
   • Communication
   • Culture change
   • Education (on-site education is known to be very effective)
   • Educating and updating private podiatry associations

2. What have you heard today that you could take back to your district?
   • Multidisciplinary & interdisciplinary clinics run by students
   • Models of care for staff
   • Medicare locals to recognise gaps in services
   • Communication / collaboration with Medicare locals

3. What could we do to prevent admissions in general?
   • Communication & links
   • Drop in clinics
   • Hotline for patients
   • Target education with Medicare locals in podiatry
   • Expansion of orthopaedics triage
   • Implement a form of Hospital in the Home
   • Can’t access funds from nursing homes – community clinics
   • No HACC services for low care

4. What could we do to prevent admissions specific to your work group?
   • Virtual Foot Ulcer Emergency Service (VFEUS)
   • Hospital in the home for diabetic foot

Diabetes in Pregnancy Discussion Group

1. What are you currently doing that addresses the network’s priorities?
   • Already admitting only as needed
   • Already using telehealth and email
   • Room to move on coding (ie how much is due to diabetes and how much is due to O&G)

2. What have you heard today that you could take back to your district?
   • Care plans
3. What could we do to prevent admissions in general?
   - Multidisciplinary team approach
   - GP incentive approaches
   - Standardised protocols, guidelines and data collection
   - Patient empowerment
   - Availability of Indigenous Health Workers

4. What could we do to prevent admissions specific to your work group?
   - Better formal education of primary health (ie early referral and postpartum management)
   - Up-skilling junior and senior medical staff
   - GDM groups for patients that provide education and support. These groups would include a dietitian and a diabetes educator.
   - Inservices and workshops for midwives and other hospital staff
   - Improved psychosocial assessment
   - Phone follow up for patients
   - Standardisation of documentation templates
   - Web-based learning modules

**Type 1 Diabetes Discussion Group**

1. What are you currently doing that addresses the network’s priorities?
   - GP / community linkages. Possibly a specialist or educator in practice. Already in place for Type 2 Diabetes – could possibly work for Type 1 Diabetes

2. What have you heard today that you could take back to your district?
   - Case coordinator (eg for recurrent DKA in established Type 1 diabetics)
   - Active GP engagement

3. What could we do to prevent admissions in general?
   - See responses to Q4

4. What could we do to prevent admissions specific to your work group?
   - GP linkages / Management plans (eg sick day plans)
   - Extend use of electronic care plans
   - Consistent access to after hours care / advice
   - Peer support
   - Team sets agreed target
   - Mental health professional within the team
   - Licences
To assist with continuous improvement please complete this form. Thank you.

<table>
<thead>
<tr>
<th>Forum/Workshop Title</th>
<th>Hospital/Organisation</th>
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<tbody>
<tr>
<td>SDCN Forum 18 May 2012</td>
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Name (Optional) Category of Staff

**Overall feedback (60% response rate)**

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<tr>
<th>Please read each statement then circle the number that best represents your response:</th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
<th>RESULT score/5</th>
</tr>
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<tbody>
<tr>
<td>1. The objectives of the forum were clearly outlined</td>
<td>65%</td>
<td>19%</td>
<td>15%</td>
<td>0%</td>
<td>0%</td>
<td>4.5</td>
</tr>
<tr>
<td>2. The forum stimulated my interest</td>
<td>46%</td>
<td>42%</td>
<td>12%</td>
<td>0%</td>
<td>0%</td>
<td>4.3</td>
</tr>
<tr>
<td>3. The presentations were useful and relevant</td>
<td>44%</td>
<td>40%</td>
<td>16%</td>
<td>0%</td>
<td>0%</td>
<td>4.3</td>
</tr>
<tr>
<td>4. The objectives of the forum were achieved</td>
<td>39%</td>
<td>42%</td>
<td>19%</td>
<td>0%</td>
<td>0%</td>
<td>4.2</td>
</tr>
<tr>
<td>5. There was sufficient time to meet the forum/workshop objectives</td>
<td>27%</td>
<td>38%</td>
<td>31%</td>
<td>4%</td>
<td>0%</td>
<td>3.9</td>
</tr>
<tr>
<td>6. There were sufficient opportunities for sharing ideas</td>
<td>23%</td>
<td>50%</td>
<td>23%</td>
<td>4%</td>
<td>0%</td>
<td>3.9</td>
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<tr>
<td>7. The forum was well organised</td>
<td>54%</td>
<td>38%</td>
<td>8%</td>
<td>0%</td>
<td>0%</td>
<td>4.7</td>
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<td>8. Information was presented in a user friendly format</td>
<td>65%</td>
<td>31%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>4.6</td>
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<td>9. The facilitator maintained a supportive and participative forum environment</td>
<td>52%</td>
<td>44%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>4.5</td>
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<tr>
<td>10. I found value in networking with colleagues</td>
<td>81%</td>
<td>12%</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
<td>4.7</td>
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<td>11. The venue used was suitable</td>
<td>43%</td>
<td>42%</td>
<td>15%</td>
<td>0%</td>
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What suggestions do you have for improvement?

The majority of the feedback was very positive regarding the informative and interesting discussions. There were several requests for speaker notes to feed back to colleagues.

Some speakers ran over their allotted time which led to several comments suggesting that improved time keeping would have enabled more time for workshop activities.

There were some calls for a more centrally located venue, such as the RBWH, for ease of access. There was also a comment requesting more notice of the forum date to allow for planning for clinical workload.

Future Presentations: Please suggest any topics or speakers you would like to see at our next forum.

There were many suggestions about future forum topics including:

- Diabetes Australia Queensland update
- Revisiting past projects to monitor their progress
- Allocated time to discuss guidelines and development
- How to deal with DNA rates
- Dental and Diabetes
- Strategies for communication with GPs and other health professionals
- Inpatient management including using the insulin guidelines.

Thank you, for taking the time to complete this evaluation form - please return completed forms to the marked box upon your departure.