Wimmera Chronic Disease Reference Group

Diabetes Services Mapping Strategy Workshop

10th October 2007 Discussion and Outcomes Report

Authored by
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Introduction

Ten professionals working with people with diabetes attended and participated in the Wimmera Chronic Disease Reference (WCDR) Group diabetes services mapping and strategy workshop held on 10th October 2007 in Horsham.

The specific objectives of this workshop included:

- To develop a shared understanding of Diabetes Services Offerings within the Wimmera through discussing the pre-workshop Diabetes Services Mapping Survey Report and the Wimmera Diabetes Services Map;

- To discuss individual and shared visions for Diabetes Services within the Wimmera catchment area;

- To undertake an analysis of the current Diabetes Services offerings against the needs; and identify the strategic opportunities for enhancing service / care and strengthening collaboration

- To develop workable solutions (strategies and actions) to the most critical challenges and gaps within the Wimmera Diabetes Services Service System

The following report identifies the key discussion points, agreed outcomes and decisions reached throughout this workshop.

Attendees:
Jason Hahne (Goolum Goolum Aboriginal Cooperative)
Leanne Lehmann (West Vic Division of General Practice)
Lesley Robinson (West Wimmera Health Services)
Carol Paech (Rural Northwest Health Services)
Natalie Smith (Wimmera Healthcare Group)
Tracey Pitts (Wimmera Healthcare Group)
Helen Forsyth (Edenhope Memorial Hospital & Edenhope Medical Clinic)
Cathy Newell (Hospital Admissions Risk Program)
Megan Milgate (TriStar Medical Group)
Donna Bridge (Wimmera Primary Care Partnership)

Discussion Points & Outcomes

1. Opening and Introductions

The forum commenced with professionals formally introducing themselves to the other professionals, following welcoming comments from Donna Bridge, Wimmera PCP, and an overview of the workshop by the facilitator.

These introductions were facilitated through using common prompts such as: Name, role, agency; length of experience working with people with diabetes; and working in the Wimmera; 1 achievement, challenge, or learning in recent times; critical issues / needs facing people with diabetes in the Wimmera Region; and Aspirations for diabetes services and for people with diabetes in the Wimmera Region.

Arising from these introductions were several noteworthy points. These included:

- Achievements, challenges and learnings were recorded as:

Achievements	Challenges	Learnings
Wimmera Chronic Disease Reference Group: getting to know all the services within the Wimmera – breadth and depth x 2	learning what a Community Health Nurse does	how each Shire works and how services get to, from, and within - regarding Chronic Disease Management
From Wimmera Chronic Disease Reference Group networking, Diabetes Educator from West Wimmera Health Services able to fill Diabetes Educator gap at Goolum Goolum.	relieving others	community management of diabetic issues
learning more about Chronic Disease and how to help people become self managers of their diabetes	other parts of my management job	re learning rural issues / context
Goolum Goolum – moving from a small service to an all encompassing Allied Health Service	networking	
diabetes Type 2 - self management – just established for newly diagnosed and up to 12 months	diabetes services are not so well co-ordinated	
	15% of Indigenous people have been diagnosed with diabetes – lots more that are pre-diabetic and haven't been diagnosed	

- Critical issues / needs facing people with diabetes in the Wimmera Region were recorded as:

- Shared assessments
- not sure what we are all doing
- family history – younger members at risk x 3
- type 2 diabetes – not enough services to support person in an ongoing way (i.e.; education, ongoing care and support) x 5
- lack of specialist care – endocrinologists etc;
- Holistic look at all social / health issues – for aging clients for our Indigenous community x 3
- co-ordination – service and care
- seeing Chronic Disease as a whole
- duplication of services
- enhance education for GPs

- Aspirations for people with diabetes and for diabetes services within the Wimmera were recorded as

    - shared understanding – whose doing what, where and when
    - enhance preventative services / earlier detection – screening; awareness; education
    - become a better diabetes educator
    - increase better more services in region specifically for later stage Type 2 diabetes
    - working together – more cohesive, stronger co-ordination and as service providers x 6
    - HARP extended beyond Horsham
    - enhance communication between service providers
    - shared idea of what' good diabetes care' is
    - better communication with broader systems – housing, disability, family violence etc;
    - enhance communication and co-ordination within own agency
    - enhance successful management of type 2 diabetes
    - good patient outcomes
    - decrease individual agency ownership of clients – increase collaborative / collective effort x 2

<u>Key messages from introductory conversations were shared as:</u>

- enhance collaboration, coordination, communication
- need / gap regarding type 2 diabetes management – ongoing education, and support – also gaps for people with type 1 diabetes
- need to strengthen partnerships / relationships with GPs
- lots of barriers to care coordination – high staff turnover – tending to breakdown in communications; Medicare encourages ownership of clients; different systems being used, that find it hard to talk with each other

2. **Diabetes Services in the Wimmera –The reality**

Significant time was invested in reviewing the Diabetes Services Survey information and reviewing and analysing Wimmera's Diabetes Services Map.

(See Attachment 1 for Diabetes Services Survey Summary Report and Attachment 2 for the Wimmera Diabetes Service Matrix.)

First reactions / comments to the Survey Summary Report and the Matrix of Services included:

- communication with own agency needs to be better
- lots of services – so leaves a lot of questions unanswered – why do we think there is not enough – is it because of inadequate advertising / profiling of these services; sheer space – tyranny of distance; funding doesn't pick up the travel requirements – only the service requirements
- top down approach rather than a population health planning and research approach
- limited specialist services
- Only two Wimmera General Practices completed the mapping survey (all were sent the survey) therefore GPs are not able to be represented completely in this Diabetes Services work. This is unfortunate as they provide services for long term care issues.
- support for carers – not enough
- waiting lists are hidden – whilst waiting lists are not held – appointments often have to be scheduled 2 – 3 weeks down the track
- dentists not mapped – critical partner in a our care system – *Leanne Lehmann (West Vic Division of GPs) will follow up free annual visit to Dentists for people with diabetes*
- counsellors / social workers and psychologists are also not mapped and are also critical partners to the diabetes care / management system

Following these first reactions / comments; professionals were encouraged to validate the information contained in the Summary report, the Matrix of Services and to view the 3 dimensional map (the visual representation of diabetes services in the Wimmera).

This 3 dimensional map mapped diabetes service provision within each of the 4 LGAs; Wimmera wide; and according to the DHS model of 4 levels of Chronic and Complex Care (differentiated by colour of Flag Pins used to indicate the location of diabetes service provision).

After this review and further discussion, an additional 5 services were included. These are services Map Reference Number 85 -89 and have been included in the Matrix at Attachment 2.

The legend for the 3 dimensional map has been reproduced in Attachment 3.

3. Diabetes Services in the Wimmera – What do we notice?

The mapping of diabetes services stimulated significant discussion. Professionals were encouraged to reflect on the map and their experiences and to consider strengths, weaknesses, opportunities and threats for effective partnerships and diabetes service improvement within the Wimmera.

The following is a record of these discussions.

Our Context

- 89 Services mapped (not exhaustive map)
- Wimmera has a population of approximately 44,000
- covering a large geography
- 15% of Indigenous people have been diagnosed with diabetes
- Diabetes is growing in ALL local government areas within the Wimmera (78% - 131% increase in diabetes prevalence since 2001)*
- need to have clear sense of the diabetes prevalence in the Wimmera

See Attachment 4 for 2001 & 2006 Diabetes Prevalence statistics. These statistics have been *sourced from Diabetes Australia – Victoria
2006 statistics – Prevalence of Diabetes in Victoria by Local Government Area

Strengths x 7	**Weaknesses x 8**
▪ WHCG is able to provide a broad support platform for all diabetes services – paediatrics to later stage ▪ we have access to quality care ▪ lots of different services in the region for people with diabetes ▪ passionate diabetes professionals in the region ▪ services available on the ground ▪ well defined treatment : cycle of care – work towards best practice ▪ outreaching regularly	▪ Lyn Fraser's Diabetes Nurse Educator role at WHCG is very pivotal and we are dependent on her expertise – and she is busy ▪ WHCG - connection between Community Health Nurse and diabetes educator is difficult as Diabetes Educator is snowed under ▪ Hospitals are focussed on acute so Community Health Services are neglected ▪ not enough funding for diabetes professionals – lack of direct funding ▪ lack of standardised guidelines for care (optometry, podiatry, Lipids, FBS etc ;) ▪ lack of follow up support – particularly for type 2

	▪ lack of multicultural health resources ▪ lack of diabetes health professionals
Opportunities x 7 ▪ other regional health services can tap into WHCG expertise of services, clinic, pumps etc; ▪ better cooperation between professionals - set up permission for patient info to be shared between professionals ▪ to develop those services further extend and integration ▪ to provided printed information on diabetes services for consumers and patients and for this to be reviewed regularly ▪ technology development – clever health ▪ lots of funding is available ▪ more mentoring for diabetes workers	**Threats x 5** ▪ decrease of services if they can't work together to attract clients / patients and referrals ▪ attracting qualified staff to region ▪ demand for services exceeds what is available and this feels overwhelming and will get worse – lack of Diabetes Nurse Educators ▪ services relying on funding from year to year - people not applying to 12 months position – stability not there ▪ GPs practice in own paradigm – cultural shift needed

4. Our Focus / Enhancing Care

Building on this analysis and a review of aspirations recorded earlier in the workshop, several WIGS (Wildly Important Goals) for diabetes services in the Wimmera were put forward. These included:

Goal	Aim / Detail	Whose responsible / Next steps
1	Focus on Prevention ▪ education by CHN; Best Start Partners; Pre-schools ▪ leverage off legislation 'Better Food Practices' - need legislation ▪ Lobbying Government ▪ Showcase (CHN – Rural N/West Health Services 'Facts on Snacks' program) ▪ activity for funding for implementation ▪ Lobby Hugh Delahunty on this – both his State Govt and VicHealth hats	PCP Executive (To be managed up through the WCDR Group)

Goal	Aim / Detail	Whose responsible / Next steps
2	Diabetes Education Guidelines ▪ shared idea of 'good diabetes care' ▪ pathways ▪ minimum services ▪ mid service ▪ maximum service levels ▪ aim: Consistency; continuity of care and reinforcement ▪ Target Group: Professionals working with people with diabetes ▪ GPs through Leanne Lehmann (WestVic Division) – needs to fit in with Cycle of Care ▪ other professionals ▪ needs GP sponsorship – needs to be consultation with GPs – Leanne to be conduit	Lesley on behalf of group to raise issue at the next Special Interest Group Meeting of Wimmera / Mallee Australian Diabetes Educators Australia
3.	Information sharing ▪ explored all barriers to effective info sharing ▪ need to refer to Special Interest group ▪ need to look at all patient held records – take the best from the best and compile own (10 most critical factors to know) ▪ develop a strategy to ensure people with diabetes take their records from appt to appt – professionals need to reinforce the importance of the patient hand held records	Lesley on behalf of group to raise issue at the next Special Interest Group Meeting
4	Population Health ▪ need accurate statistics – incidences; type; area ▪ need to undertake research – need to be able to use local information and wisdom (research) to advocate around service gaps etc; Donna (PCP) to conduct secondary research. Primary research – consider partnering with local tertiary institutions for research students	PCP to pull together regional diabetes statistics and to look at partnerships with tertiary institutions for primary research. WCDR Group to set research questions.
5	Evaluation ▪ need to get better at evaluation – understanding the impact and outcomes of our services	To be taken to the WCDR Group as a point to discuss

5. Closing

The forum closed with feedback and closing words from the facilitator and Donna Bridge, Wimmera PCP, thanking all for their contribution and commitment to the pre work leading up to the workshop and for their active discussion at the workshop.

Feedback regarding the workshop by professionals

- good – come away with tangible actions
- scratches the surface – but it's a start
- a stepping stone
- good to realise everybody has similar challenges
- still have concerns for people with type 2 diabetes
- good to come here and understand system challenges
- good support
- reinforcement that new services will hit the mark

It was agreed that an Outcomes and discussion report be prepared by the facilitator and distributed through Donna (PCP) to all participants and discussed at the next WCDR Group meeting.

Attachments

Attachment 1 - Diabetes Services Survey Summary report

Attachment 2 - Matrix of Diabetes Services in the Wimmera

Attachment 3 - Legend for Diabetes Services Map

Attachment 4 - Wimmera Region 2006 Diabetes Prevalence statistics (sourced from Diabetes Australia Victoria's website)

Attachment 1

Wimmera Diabetes Services October 2007
Summary of Survey Responses

Introduction

The Wimmera Chronic Disease Reference (WCDR) Group identified mapping of chronic disease services as a priority for the Wimmera region. The aim of their mapping processes is to identify any unmet needs, key target groups / and/or possible areas of duplication. Considering the breadth of services and scope of undertaking these mapping exercises, the CDR Group decided to focus on Diabetes as a starting point and then expand this work across the chronic disease spectrum in the near future.

To begin this process the WCDR Group distributed a Diabetes Services Mapping Survey early September 2007, requesting services complete responses to a series of 10 questions and to complete a table outlining the diabetes-related activities their agency is involved in, either as a lead organisation or in partnership.

This report summarises the responses to the survey questions. This report coupled with the full table report comprises the full breadth and depth of all survey responses.

Survey Response Rate & Survey Respondents

A total of 20 surveys were returned from the possible 30 providing a 67% response rate.

Of those returned (20), 17 respondents indicated their agency delivered targeted programs / service towards persons either at risk of or with Diabetes (Type 1 or 2) or aimed at addressing contributing factors of Diabetes.

Of the three ‘No’ responses; two respondents still completed the remainder of the survey and therefore their data has been included.

Survey responses were received predominately by public providers in the Acute and Community Health sectors (10). Private providers rated second highest with 5 responses, followed by Local Government (x2).

It should be noted that descriptions provided from respondents regarding the areas their service targets (Question 3 & 4), and their descriptions re their activities in their tables, were different. To avoid missing services / programs on the 3-dimensional map, some information may be replicated.

Frequency of Categories for Diabetes related activities

Respondents were asked to categorise their Diabetes activities to the category their activities fit more closely with. The following table represents the 8 categories and the frequency of the response. It should be noted that several agencies offer a range of activities covering more than two and in some cases more than 4 categories.

Category of activity	Frequency category was circled
clinical service delivery	**11**
community development	**2**
support services	**6**
health promotion / prevention	**13**
education / professional development / capacity building	**6**
research	
population health planning	**1**
other	

As this table highlights, most activity within the Wimmera region relates to clinical service delivery and health promotion / prevention. This table also indicates that respondents don't undertake activity within the Wimmera relating to *diabetes research.*

Areas services target

Respondents were asked to list the area and type of intervention their services targeted and proportion a % of their work in diabetes against each of these areas.

The following is a summary (frequency and the ranges of % of diabetes work in each area) of the responses received.

Area	Type of Intervention	% of work in diabetes
Primary Prevention	11	5% - 100%
Secondary Prevention	11	5% - 80%
Tertiary Prevention	11	5% - 80%
Long Term care and support	7	7.5% - 60%
Care and Support for acute episodes	6	7.5% - 10%
Support of Carers	5	

As this table highlights the greatest percentage of work occurs within the Primary, secondary and tertiary prevention areas (DHS Level 4 and Level 3), and the least work occurs in the Care and Support for acute episodes area.

The most common work within the primary prevention areas included:

- exercises – physical activity sessions
- community education sessions
- diet consultations

The most common work within the secondary prevention areas included:

- screenings – in a variety of settings and for a range of issues (foot care; eye care; BSL; etc)

The most common work within the tertiary prevention areas included:

- consultation re diabetes management / care plans / case coordination
- monitoring of existing diabetics

Agency referrals

Most agencies that responded indicated they referred their clients/ patients to other services. The services that were most referred to included:

Referrals to	Frequency
Diabetes educator	10
dietician	8
Counsellor	5
Active Script	3
Physiotherapist / exercise	10
Podiatrist	9
Domiciliary Nursing	6
Others	Optometrist x 3 ophthalmologist x 4 surgeons for gastric banding endocrinologist

As this table reveals, referrals to diabetes educators and physiotherapists were the most frequent referrals; followed closely by referrals to podiatrists and dieticians.

Referral methods

Referrals made to the above services were mostly made by verbal recommendation (9) and by paper based methods – referral letters provided to service (9) and referral letters provided to clients(6).

Only five agencies indicated they used the state-wide referral form or other standard tool such as the (SCoTT).

Waiting Lists

All services indicated they didn't have waiting lists although two respondents qualified their response by stating that the standard wait for optometry consultations was between 1 – 2 weeks and for diabetes educators a couple of days dependent when the educator was in the smaller towns.

Six respondents indicated waiting lists in other services within the Wimmera region.

These waiting lists related to

- podiatry 2 – 3 weeks;
- Hospital Podiatrist: 2 – 6 months; (assessment only; not offering ongoing care)
- Hospital Diabetes Educators – not seeing new Type 2 diabetics;
- Hospital dietician: 3 – 6 weeks.

Identified unmet needs or specific population groups at risk in relation to Diabetes in the Wimmera

Several respondents identified unmet needs or specific population groups at risk of diabetes within the Wimmera. These included:

- Aboriginal and Torres Strait Islander population group one of the highest risk groups – needs not met
- low income people with diabetes (lower income means that these diabetics don't get the foot care they need such as cutting nails as they don't see this as a priority)
- diabetes educators within Minyip; Murtoa; and Rupanyup areas (for Type 1 and 2 diabetes)
- older clients are house bound – some don't drive - making keeping their appointments difficult - transport difficulties
- Diabetics who work 9 am – 5 pm (as most services are provided during the day)
- lower socio economic groups who are not eligible for pension / HCC – to assist with the cost of allied health or purchasing of equipment for diabetes management
- need guidelines re frequency of eye examinations – currently different standards and practices ranging from 12 months to 2 years
- current / updated list of diabetes educators

Attachment 2 **Matrix of Wimmera Diabetes Services October 2007**
(Information gleaned from survey responses)

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
Dunmunkle Health Service		Exercise programs Screenings Diabetes: cycle of care assessments Diabetes monthly group sessions	1 2 3 4			Minyip; Murtoa and Rupanyup		
Wimmera Foot Clinic		General Foot Care Neurological and vascular assessments Education regarding risks to foot health due to diabetes Regular foot care Treatment of ulcers	5 6 7 8 9			Border, Up to Mildura, Stawell and Horsham and Districts		

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
Ross Booth & Associates (Optometrists)	Informal partnerships with local GPs Diabetic eductors	Optometry Screening Optometry Monitoring	10 11		Current population with diabetes	Wimmera Region	Medicare	Strengths: diagnostic equipment and skills
Yarriambiack Shire Council		Tai Chi and Gentle Exercise programs	12			6 of 13 towns within LGA Patchewollock Woomelang Hopetoun Minyip Murtoa Rupanyup		
West Wimmera Health Services / Dietetics Dept	DHS	Education sessions with children and families Consultation re diabetes management	13 14	To Improve the health, activity levels and well being of older persons To improve the health of persons with diabetes and to provide support	Persons attending day centres across the service Diagnosed with Diabetes in the area	Nhill; Kaniva; Rainbow; Natimuk; Goroke Nhill	DHS & Health Service Health Service	
Knight and Associates (Optometrists)	Practices in Stawell, Warracknabeal; and Horsham	Screening new onset Monitoring existing diabetics	15 16	earlier detection and referral to ophthalmologist if need be		Wimmera / Southern Mallee	Bulk billed - Medicare	Challenges: - paperwork by GP: cost and storage issues - cost of retinol photography to document any changes

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
Edenhope and District Memorial Hospital		Exercises classes – -chair based - water based - active to music - tai chi Exercises classes offered to schools Screening - street Diabetic Nurse for care plans Diabetic support group Education Sessions Aged care residential services Hospital admissions for acute chronic episodes	17 18 19 20 21 22 23 24	To improve health and well being All diabetics eligible All diabetics eligible All diabetics eligible All diabetics eligible All diabetics eligible	open all ages Men only classes	Edenhope and surrounding community	Hospital through their funding	Strength: Diabetes educator also works at Drs Surgery – continuity of care and familiarity for clients

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
West Wimmera Health – Community Health		Exercises classes (older adults)	25	falls prevention reduce chronic disease	60+	Community: Nhill; Jeparit; Rainbow	DHS through Community "Women's Program"	Challenges: Attendances in small towns
	West Vic Division of GPs	Active Script Enabler	26		60+	Goroke; Nhill; Kaniva; Jeparit; Rainbow	DHS through Community "Women's Program" Go 4 Your Life funding	Referrals from GPs are slow
	Learning group N/hood house' M&CHN Wimmera Regional Sports Assembly	Moovers and Shakers – walking group	27		Young Mothers Adults	Nhill; Kaniva; Jeparit; Rainbow		Identifying and training leaders
		Health screening	28					
		Through District Nurse – support to other staff	29 / 30					
Goolum Goolum		Diet education	31	Prevention, early detection and management of diabetes in Indigenous clients	All type 1 & 2 Indigenous diabetics (35) as well those at risk	Central Western Victoria	Federal Govt – recurrent (OATSIH)	Challenges: Limited GP time for chronic disease management Strength: access to all necessary
		Fitness assessments	32					

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
		Screening – health checks Diabetes management plans & Care coordination Allied Health services – podiatry; dietician	33 34 35					allied health at the health service; reducing cultural barriers
Rural Northwest Health: Community Health	- Wimmera PCP - West Vic Division of GPs - Educator ass - Diabetes Australia	Community Education – preschool; primary school and adult Random Blood Sugar Level screenings Diabetes Educator General Carers Support Gp	36 37 38 / 39 40			Warracknabeal in the south to north on Hopetoun	Yarriambiack Rural Health Alliance Federally funded 3 yearly – brokered – not recurrent – needs to be applied for (Due end Fin Year 2008)	
Rural Northwest Health: Diabetes Educator		Diet Exercise Screenings	41 42 43		People diagnosed with diabetes, those identified at risk	Warracknabeal, Beulah, Hopetoun		Primary care centre with a number of allied health staff

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
	Diabetes educators GPs Diabetes educators GPs Diabetes educators GPs Diabetes educators	Self management education Care coordination Long term care and support Care and Support for acute episodes Support groups and Individual visits	44 45 46 47 48	Educate to live well with diabetes. Minimise complications Keep track of complication screening Less formal group to discuss issues and concerns about staying well	People with diabetes who do not venture to other services other than the GP clinic		Rural Northwest Health Diabetes Australia – Victoria	Self management aim Groups meet during the day as most attendees are retired, not a lot of information available in the evenings
Rural Northwest Health: Diabetes Educator		Podiatrist	86					Monthly at Hopetoun; weekly at Warracknabeal
Rural Northwest Health: Diabetes Educator		Physiotherapist	87					Weekly at Hopetoun;

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
Rural Northwest Health: Diabetes Educator		Exercise physiologist	88					Full time
Rural Northwest Health: Diabetes Educator		Dietician – sub contracted from West Wimmera Health Service	89					Weekly
West Wimmera Health Service		Podiatrists	49	To prevent and treat complications of the feet of people diagnosed with diabetes	People with type 1 and type 2 diabetes	Nhill; Rainbow; Jeparit; Kaniva; Goroke; Natimuk	DHS – ongoing	2 Podiatrists – but have long waiting lists
	Diabetes Australia Victoria	West Wimmera Diabetes Support Group	50	To provide education and support for people with diabetes and their families	All people with diabetes and their families	Nhill	Diabetes Australia / Victoria small amount of funding annually & DHS	Facilitated by Diabetes educator of WWHS
	West Wimmera Health Service	Visiting optometrist and ophthalmologist	51	To screen and treat diabetes complications of the eye	All people with diabetes	Nhill		
	Australia diabetes educators	Diabetes education	52	To improve health and well being of those	People with IGT; type 1 and type 2	Nhill; Rainbow; Jeparit;	DHS	Credentialed diabetes educator; .8 EFT

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
	association			diagnosed with IGT; type 1 and type 2 and gestational diabetes through self management education	and gestational diabetes	Kaniva; Goroke; Natimuk		spread between all towns (per week and per month basis)
Hindmarsh Shire Council		Support Services in Home	53					
Tristar Medical Group – Horsham Medical Centre	Other health care providers Warracknabeal Medical Centre	Diabetes Education Service Ongoing diabetes	54 55	Provide self management skills to people with diabetes to assist them in the management of their diabetes	Type 1 and Type 2 diabetes GDM Newly diagnosed diabetes Type 1 and Type 2 diabetes GDM Newly diagnosed diabetes	Horsham city and surrounding districts Also clients of the Warracknabeal Medical Centre	Medicare	Challenge: Funding – difficult when there are only 5 allocated allied health visits per year to share between diabetes education, podiatry etc;

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
Hopetoun and District Neighbourhood House		Physical activity sessions Diabetes Support Group	56 57		Open	Hopetoun District	Dept Planning and Community Development (Vic)	Challenge: Enough Time, auspiced by a body (Gateway Beet) and so we are not a stand alone entity (politics)
Edenhope & District Memorial Hospital Edenhope Medical Clinic		Diet Exercise BP Controlled Weight Medical Review Referrals for medical review Diabetes reviews at Drs Clinic 3-6 months review of clients check hospitals / patient's reviews (nursing home and hostel)	58 59 60 61 62 63 64 65 66			Edenhope and District		Diabetes Education at Edenhope And District Memorial Hospital – one day a fortnight Diabetes Resource practice Nurse at Edenhope Medical Clinic – one day a fortnight

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
		ComNet Diabetes Support Group	67	Address areas of interest of members support group	All people with diabetes and their cares	Edenhope	ComNet $ 250 per year	Core group well educated. Challenge is to reach other people with diabetes
Wimmera Health Care Group Primary Care Services (10 x et al)		WHCG Health Promotion Plan 2006-2009 – Physical activity - early bird exercise program for expectant mothers - walk to work program Strength / resistance Training in Dimboola - women on Farms physical activity information kits	 68					
		HARP-CDM - Walking group - Gym group - Information sessions on health related needs	69		for people with chronic illness			

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
		CRC - Cardiac Rehabilitation Program - Strength and Resistance Group - Individual physical activity rehabilitation plans	70					
		CHN - Health screenings @ Wimmera Machinery Field Day incorporating BSL reading - Workplace health screenings incorporating BSL reading	71					
		Diabetes Service (DNE) - Paediatric / Youth & specialised delivery devices (pumps). - Aged care reviews undertaken for	72		Focus to Inpatient (all presentations to WHCG) & outpatients: Type 1 , Gestational Diabetes,			

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
		WHCG. - Regional clinic developed, - specialised regional paediatric and youth clinics						
		HARP –CDM - Development of Diabetes stream	73		for people with chronic illness			
	conducted in-conjunction with Allied Health services & CRC staff	CHN -Diabetes Self Management Program - Diabetes Education Group	74		for people newly diagnosed with Type 2 diabetes			
		DNS/CRC/DC/ WHC Clinical assessment, often incorporating BSL & care plan education (including specialised nursing services: wound care, continence & palliative	75					

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
		care)						
		WCO - Development of packages of care to support	76		people with chronic illness			
		DNS Deliver of post acute support services on discharge from acute care settings (HITH, HTH, Post Acute)	77					
		Diabetes Service -Youth camps - Regional specialty clinics - develop other DNE's into role and provide follow up on specialised delivery devices - Community group education & information sessions	78		for young people diagnosed with Type 1 Diabetes and their families for review of children/ support families,			

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
		-Skilling of families – 1:1 consultation and group sessions -Skilling of WHCG health and medical professionals -Skilling and mentoring of nursing staff (TAFE/ Uni B/ Mayfield) -Skilling of teachers for care of children with diabetes						
Royal Children's Hospital Melbourne	WHCG Services SW Health Services Western Health Services	Regional Paediatric Endocrinologist Review Clinics	79	Medical and specialised nursing review of paediatric clients with Type 1 Diabetes	Wimmera based children and their families Diagnosis of Type 1 Diabetes	Hospital outreach from specialised metropolitan service	DHS, recurrent ¼ clinics	Availability of DNE's for clinic – care plan development and post follow up Coordination of clinic HbA1c testing
WHCG - Diabetes Service		Young Adults Clinic	80	Medical and specialised nursing review of young adults (16-30 with Type 1	Wimmera based youth and their families/ partners	Hospital outreach to ensure young adult clients have continued medical and	WHCG ¼ clinics	Setting up and coordination of clinics Specialised medical input

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
				Diabetes	Diagnosis of Type 1 Diabetes	specialised nursing review. Identified as "at risk" group		availability and allied health support
WHCG – Diabetes Service	Dimboola Health Service Ararat Health Service Stawell Health Service	Regional Clinic	81	Specialised nursing review of children with Diabetes Type 1 in-conjunction with local regional DNE's. Aim; to develop local resources for specialised needs	Wimmera based children and their families Diagnosis of Type 1 Diabetes	Community based program during school hours in Ararat, Stawell & Dimboola Professional nursing mentoring for other DNE's School teacher training, as required	WHCG Monthly	Commitment and understanding by various health services that there is a need for DNE mentoring to develop support services for children with Type 1 Diabetes
WHCG – Diabetes Service		Continuous Glucose Monitoring System (CGMS) Clinic	82	Management tool giving tangible 72-hour tracing of a person's blood glucose -Informs for diabetic management changes -Increases understanding of management	Person with diagnosis of diabetes	Wimmera region	WHCG 2 monthly	Co-ordination of clinic and care follow up needs

Lead Organisation	Partner Organisations	Activity or Program	Map Ref No:	Goal	Population Group	Target Areas	Funding avenues	Service Specific characteristics
				requirements				
WHCG – HARP-CDM		CDM – Diabetes (chronic illness)	83	To establish CDM stream of care related to people with chronic illness, in particular diabetes	To be established	Horsham LGA	SACS - recurrent	Establishment of program stream
WHCG – Community Health Nursing Service	Wimmera PCP Division of GP's Other regional community health centres	Diabetes Self Management Program	84	To improve the health and wellbeing of people with a recent diagnosis of Type 2 diabetes	Recent diagnosis of Type 2 Diabetes	Initially Horsham LGA with expansion across to other regional areas	Community & Women's Health - recurrent	Establishment if program Recruitment of staff and client to program
WHCG		Careers Respite Centre	85					

Attachment 3 **Wimmera Diabetes Services October 2007 – LEGEND FOR 3D MAP (Information gleaned from survey responses)**

Lead Organisation	**Activity or Program**	**Map Ref No:**	**Target Areas**
Dunmunkle Health Service	Exercise programs Screenings Diabetes: cycle of care assessments Diabetes monthly group sessions	1 2 3 4	Minyip; Murtoa and Rupanyup
Wimmera Foot Clinic	General Foot Care Neurological and vascular assessments Education regarding risks to foot health due to diabetes Regular foot care Treatment of ulcers	5 6 7 8 9	Border, Up to Mildura, Stawell and Horsham and Districts
Ross Booth & Associates (Optometrists)	Optometry Screening Optometry Monitoring	10 11	Wimmera Region
Yarriambiack Shire Council	Tai Chi and Gentle Exercise programs	12	6 of 13 towns within LGA Patchewollock Woomelang Hopetoun Minyip Murtoa Rupanyup
West Wimmera Health Services / Dietetics Dept	Education sessions with children and families	13	Nhill; Kaniva; Rainbow; Natimuk; Goroke

Lead Organisation	Activity or Program	Map Ref No:	Target Areas
	Consultation re diabetes management	14	Nhill
Knight and Associates (Optometrists)	Screening new onset Monitoring existing diabetics	15 16	Wimmera / Southern Mallee
Edenhope and District Memorial Hospital	Exercises classes – -chair based - water based - active to music - tai chi Exercises classes offered to schools Screening - street Diabetic Nurse for care plans Diabetic support group Education Sessions Aged care residential services Hospital admissions for acute chronic episodes	17 18 19 20 21 22 23 24	Edenhope and surrounding community
West Wimmera Health – Community Health	Exercises classes (older adults) Active Script Enabler Moovers and Shakers – walking group Health screening	25 26 27 28	Community: Nhill; Jeparit; Rainbow Goroke; Nhill; Kaniva; Jeparit; Rainbow

Lead Organisation	Activity or Program	Map Ref No:	Target Areas
	Through District Nurse – support to other staff	29 / 30	Nhill; Kaniva; Jeparit; Rainbow
Goolum Goolum	Diet education Fitness assessments Screening – health checks Diabetes management plans & Care coordination Allied Health services – podiatry; dietician	31 32 33 34 35	Central Western Victoria
Rural Northwest Health: Community Health	Community Education – preschool; primary school and adult Random Blood Sugar Level screenings Diabetes Educator General Carers Support Gp	36 37 38 / 39 40	Warracknabeal in the south to north on Hopetoun
Rural Northwest Health: Diabetes Educator	Diet Exercise Screenings Self management education Care coordination Long term care and support Care and Support for acute episodes	41 42 43 44 45 46 47	Warracknabeal, Beulah, Hopetoun

Lead Organisation	Activity or Program	Map Ref No:	Target Areas
	Support groups and Individual visits Podiatrist Physiotherapist Exercise physiologist Dietician	48 86 87 88 89	 Monthly at Hopetoun; Weekly at Warracknabeal Weekly at Hopetoun Full time Weekly
West Wimmera Health Service	Podiatrists West Wimmera Diabetes Support Group Visiting optometrist and ophthalmologist Diabetes education	49 50 51 52	Nhill; Rainbow; Jeparit; Kaniva; Goroke; Natimuk Nhill Nhill Nhill; Rainbow; Jeparit; Kaniva; Goroke; Natimuk
Hindmarsh Shire Council	Support Services in Home	53	Hindmarsh LGA
Tristar Medical Group – Horsham Medical Centre	Diabetes Education Service Ongoing diabetes	54 55	Horsham city and surrounding districts Also clients of the Warracknabeal Medical Centre
Hopetoun and District Neighbourhood House	Physical activity sessions Diabetes Support Group	56 57	Hopetoun District
Edenhope & District Memorial Hospital Edenhope Medical Clinic	Diet Exercise BP Controlled Weight	58 59 60 61	Edenhope and District

Lead Organisation	Activity or Program	Map Ref No:	Target Areas
	Medical Review Referrals for medical review Diabetes reviews at Drs Clinic 3-6 months review of clients check hospitals / patient's reviews (nursing home and hostel) ComNet Diabetes Support Group	62 63 64 65 66 67	 Edenhope
Wimmera Health Care Group Primary Care Services (10 x et al)	WHCG Health Promotion Plan 2006-2009 – Physical activity - early bird exercise program for expectant mothers - walk to work program Strength / resistance Training in Dimboola - women on Farms physical activity information kits	68	
	HARP-CDM - Walking group - Gym group - Information sessions on health related needs	69	
	CRC - Cardiac Rehabilitation Program - Strength and Resistance Group - Individual physical activity rehabilitation plans	70	
	CHN - Health screenings @ Wimmera Machinery Field Day incorporating BSL reading - Workplace health screenings incorporating BSL reading	71	

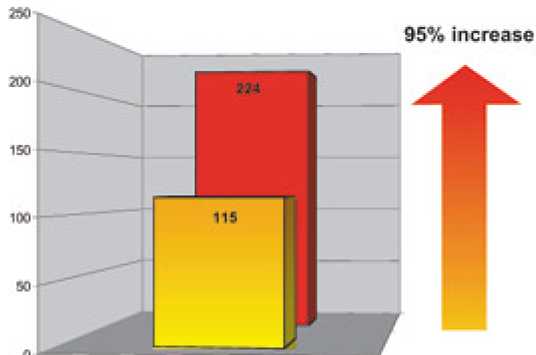
Lead Organisation	Activity or Program	Map Ref No:	Target Areas
	Diabetes Service (DNE) - Paediatric / Youth & specialised delivery devices (pumps). - Aged care reviews undertaken for WHCG. - Regional clinic developed, - specialised regional paediatric and youth clinics	72	
	HARP –CDM - Development of Diabetes stream	73	
	CHN -Diabetes Self Management Program - Diabetes Education Group	74	
	DNS/CRC/DC/ WHC Clinical assessment, often incorporating BSL & care plan education (including specialised nursing services: wound care, continence & palliative care)	75	
	WCO - Development of packages of care to support	76	
	DNS Deliver of post acute support services on discharge from acute care settings (HITH, HTH, Post Acute)	77	
	Diabetes Service -Youth camps - Regional specialty clinics - develop other DNE's into role and provide follow up on specialised delivery devices - Community group education & information sessions -Skilling of families – 1:1 consultation and group sessions	78	

Lead Organisation	Activity or Program	Map Ref No:	Target Areas
	-Skilling of WHCG health and medical professionals -Skilling and mentoring of nursing staff (TAFE/ Uni B/ Mayfield) -Skilling of teachers for care of children with diabetes		
Royal Children's Hospital Melbourne	Regional Paediatric Endocrinologist Review Clinics	79	Hospital outreach from specialised metropolitan service
WHCG - Diabetes Service	Young Adults Clinic	80	Hospital outreach to ensure young adult clients have continued medical and specialised nursing review. Identified as "at risk" group
WHCG – Diabetes Service	Regional Clinic	81	Community based program during school hours in Ararat, Stawell & Dimboola Professional nursing mentoring for other DNE's School teacher training, as required
WHCG – Diabetes Service	Continuous Glucose Monitoring System (CGMS) Clinic	82	Wimmera region
WHCG – HARP-CDM	CDM – Diabetes (chronic illness)	83	Horsham LGA
WHCG – Community Health Nursing Service	Diabetes Self Management Program	84	Initially Horsham LGA with expansion across to other regional areas
WHCG – Community Health Nursing Service	Careers Respite Centre	85	

Attachment 4 Wimmera Region 2006 Diabetes Prevalence statistics (sourced from Diabetes Australia Victoria's website)

WEST WIMMERA SHIRE

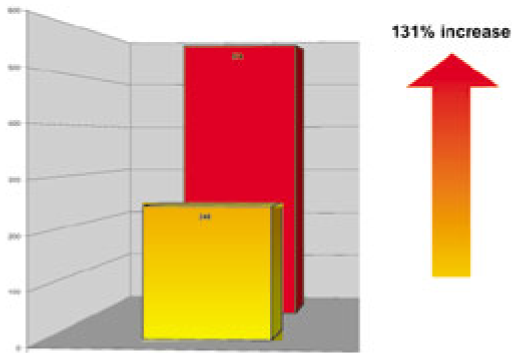
2001	
Prevalence of diabetes:	**115**
% of Population:	**2.4%**
LGA Ranking:	**25**
2006	
Prevalence of diabetes:	**224**
% of Population:	**4.8%**
LGA Ranking:	**13**



number of people with diabetes in 2001
number of people with diabetes in 2006

HORSHAM RURAL CITY

2001	
Prevalence of diabetes:	**248**
% of Population:	**1.3%**
LGA Ranking:	**73**
2006	
Prevalence of diabetes:	**574**
% of Population:	**3.0%**
LGA Ranking:	**55**

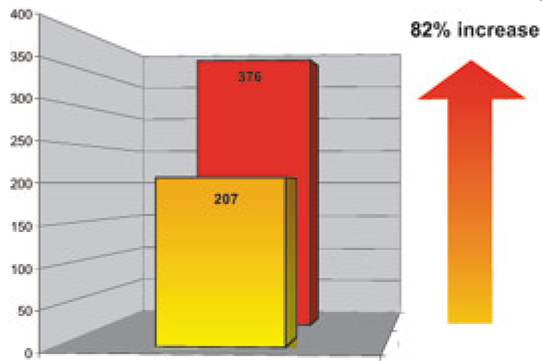


number of people with diabetes in 2001

number of people with diabetes in 2006

YARRIAMBIACK SHIRE

2001	
Prevalence of diabetes:	**207**
% of Population:	**2.5%**
LGA Ranking:	**19**
2006	
Prevalence of diabetes:	**376**
% of Population:	**4.8%**
LGA Ranking:	**12**



number of people with diabetes in 2001
number of people with diabetes in 2006

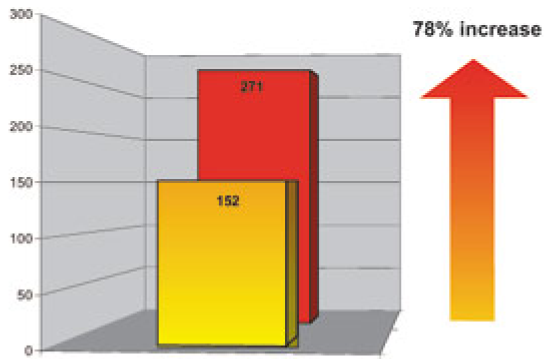
HINDMARSH SHIRE

2001

Prevalence of diabetes:	**152**
% of Population:	**2.3%**
LGA Ranking:	**30**

2006

Prevalence of diabetes:	**271**
% of Population:	**4.3%**
LGA Ranking:	**25**



number of people with diabetes in 2001

number of people with diabetes in 2006