NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Spotlight on virtual care: Western Sydney Diabetes

Western Sydney Local Health District

NOVEMBER 2022

A collaboration between local health districts, speciality health networks, ACI and eHealth NSW.

The 'Spotlight on Virtual Care' reports showcase innovation and leadership in virtual health care delivery across NSW. The series aims to support sharing of learnings across the health system and outlines the key considerations for implementation as identified by local teams.

Each initiative within the series was selected and reviewed through a peer-based process. While many of the initiatives have not undergone a full health and economic evaluation process, they provide models that others may wish to consider and learn from.

These reports have been documented by the Virtual Care Accelerator (VCA). The VCA is a multi-agency, clinically focused unit established as a key partnership between eHealth NSW and the ACI to accelerate and optimise the use of virtual care across NSW Health as a result of COVID-19. The Virtual Care Accelerator works closely with Local Health Districts (LHDs) and Specialty Health Networks (SHNs), other Pillars and the Ministry of Health.

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Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **aci.health.nsw.gov.au**

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Introduction

Around one in eight adults, or 13% of the population, in Western Sydney Local Health District (WSLHD) has diabetes. Figures indicate that the prevalence of diabetes is higher than both state and national averages, and more than 30% higher than the rates of diabetes in more affluent areas, such as Sydney's Northern Beaches or South Eastern Sydney. An estimated 30% of the adults living in WSLHD are at high risk of developing type 2 diabetes, while nearly one in five people presenting to local hospitals and emergency departments have blood sugar levels indicative of diabetes.

There are several vulnerable groups in WSLHD who are more likely to develop diabetes. These include people from culturally and linguistically diverse communities and people who identify as Aboriginal. Aboriginal people are twice as likely to develop type 2 diabetes than non-Indigenous people of the same age and gender. Considering the high prevalence of diabetes and even higher rate of pre-diabetes, significant attention is needed to slow the development of this growing epidemic, and prevent type 2 diabetes where possible in the population.

Western Sydney Diabetes (WSD) traditionally provided in-person outpatient clinics for people with diabetes.

In late 2019, as an early adopter of myVirtualCare, WSD used the platform to establish video case conferencing with GPs. In 2020, in response to COVID-19, the service stopped offering in-person care and switched all services to virtual care. It was able to resume in-person clinics in 2022. A blended model is now offered, providing increased flexibility and choice for consumers across WSLHD.

The service offers five clinics for people with type 2 diabetes:

- High Risk Foot Service
- Post-discharge Diabetes Clinic
- Mount Druitt Community Diabetes Clinic
- Blacktown Hospital-based Clinic
- Westmead Hospital-based Clinic.

The community diabetes clinic in Mount Druitt is run by GPs with a focus on capacity building for GPs and stabilisation of patients. The clinic operates under the supervision of an endocrinologist/diabetes specialist and nurse practitioner. GPs who practice in the Mount Druitt community are offered six-month rotations as GP visiting medical officers to work at the clinic. They are able to learn from the specialist diabetes clinicians and return to their community practices knowing how to best manage complicated diabetes.

In addition to the clinics, WSD developed more than 30 GP education and 100 instructional videos that can be shared via GoShare – an Australian-developed online platform. This enables efficient and measurable sharing of health resources, tailored to patients' information needs. The service also runs virtual masterclasses to build capacity of GPs and other community providers. More than 1,200 clinicians have been involved since the masterclasses began in 2019.

WSD also created the Pharmacy Working Group, comprising representatives from the district's

hospitals, community pharmacies, the Pharmaceutical Society of Australia and the Pharmacy Guild. Several pharmacists were certified diabetes educators and already servicing people living with diabetes in the community. These pharmacists were then able to assist with the application of the Flash Glucose Monitoring (fGM) device, if the patient preferred their pharmacist to do this. Where required, WSD provided training to the pharmacist to provide this role. Alternatively, patients could opt to have their fGM device fitted at nurse-led clinics at the hospital. They were shown how to use the device and taught how to collect the data using their smartphone or reader device.

Background

The prevalence of type 2 diabetes across the district is estimated by NSW Health to be 13%, based on telephone surveys conducted in 2019. However, 18% of adults attending local emergency departments or GPs have blood tests consistent with diabetes. This equates to approximately one in five adults in those healthcare settings. With an estimated 30% of people in the area living with a high risk of developing diabetes, strategies to address this issue are needed to reduce the:

- prevalence of diabetes
- significant burden of disease.

Diabetes leads to complications such as retinopathy and foot ulcers that have a higher prevalence in some western Sydney communities.

The ever-changing landscape of emerging medications and treatment options for diabetes means that close management helps people better manage their condition.

HbA1c is a blood test measuring glycated haemoglobin and indicates long-term glycaemic control. When this value is <7% it is an indication that person's diabetes is well managed. When this marker is elevated (usually above 7%) it can indicate an increased risk of developing complications.[†] WSD found that up to half of the population with diabetes who attended GP clinics had HbA1c levels above 7%.

To address these factors, WSD proposed using the Diabetes Case Conference model. GPs could refer high-risk patients who could benefit from specialised input from a multidisciplinary team that includes:

- an endocrinologist
- dietitian
- specialist diabetes nurses.

The patient's GP is also involved until the patient's blood sugars are under control. The patient is then discharged from WSD, back to their GP.

The Diabetes Case Conference model builds the capacity of GPs and patients to better manage complicated diabetes. The early adoption of myVirtualCare meant the service could continue to run during the pandemic. This was essential for people living with diabetes.

Patient benefits

- Reduction of HbA1c levels after three months and for up to three years.
- Builds the capacity of patients to self-manage their diabetes by involving them in case conferences and providing access to relevant resources, such as how-to videos.
- Access to a specialist multidisciplinary team earlier than the standard referral process to support the management of their health in partnership with their GP.
- Involvement of the patient's GP enhances care coordination.
- Reduced cost of accessing care as people do not need to pay for travel or parking.
- Use of fGM device allows patients to monitor their glucose levels more frequently before a case conference. This can lead to better awareness of how glucose levels are linked to food, lifestyle and medication.

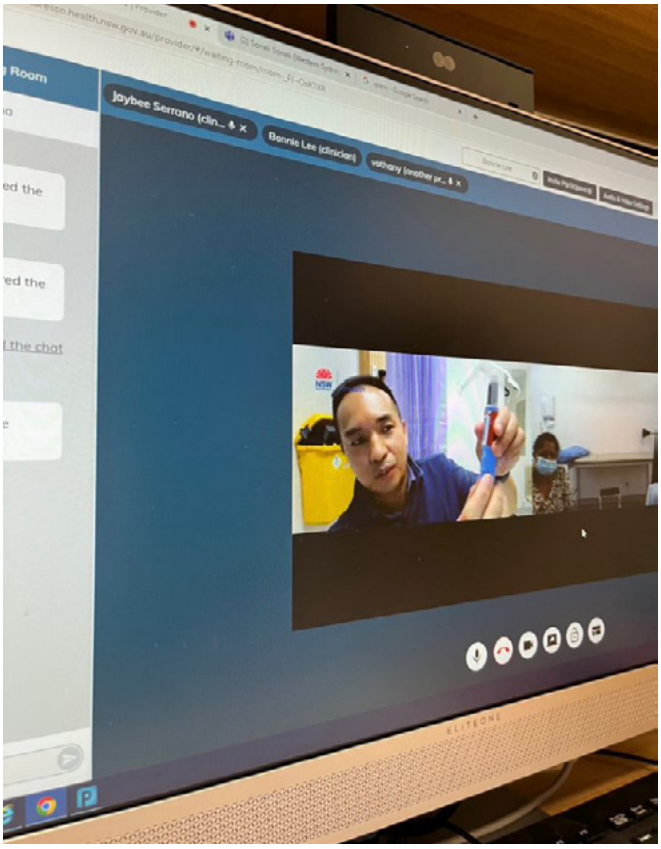
[†] Wang M, Hng TM. HbA1c: More than just a number. Aust. J. Gen. Pract. [Internet]. Sept 2021 [cited September 2022]; 50(9) Available from: https://www1.racgp.org.au/ajgp/2021/september/more-than-just-a-number doi: 10.31128/AJGP-03-21-5866

Clinician benefits

- Builds capacity of GPs to keep abreast of innovations in diabetes treatment, to help develop chronic disease management plans for complicated diabetes.
- GPs are involved as partners in care and able to ask questions of the endocrinologists directly during consultations.
- GPs are given the opportunity to work in the WSD service and be supported by an endocrinologist to manage patients.
- Builds a partnership to manage diabetes in the community, providing increased satisfaction and ability to address the prevalence of chronic disease in western Sydney.
- Multidisciplinary team approach fosters collegiality and skill enhancement for all clinicians involved, including the WSD team, with oversight of a senior endocrinologist.

Service benefits

- Improved continuity of care because people remain supported by their GP.
- Better coordination of care.
- Improved capability of GPs.



Credentialled Diabetes Educator Jaybee Serrano demonstrates an insulin pen to a patient during a myVirtualCare consult.

Overview of the model

Key elements of the model

Element	Detail
Patient population or service users	• People living within WSLHD with type 2 complicated diabetes
Referral pathway	• Referrals are sent to WSD (via fax, email or post) – if more information is required, it is requested by the advanced trainee who contacts the GP directly • The WSD advanced trainee triages referrals to one of the services and provides a time frame: – same day or week – two weeks – four weeks – three months • Appointments are allocated based on a patient's needs, location and required time frame.
Team	• The WSD team consists of: – medical staff (endocrinologist/diabetes specialist, advanced trainee, resident medical officer) – advanced trainees – recruited by Blacktown Hospital specifically for WSD for their final year of training – nursing staff (diabetes nurse practitioner, credentialled diabetes educators, research nurse) – dietitian – podiatrist (for High Risk Foot Service) – GP visiting medical officers – dedicated administration staff • In the community: – GPs – integegrated care nurse facilitators and care navigators – pharmacist from four local community pharmacies – primary health network practice support and digital teams
Technology	• Videoconferencing platform – myVirtualCare • Flash glucose monitoring device (fGM) • GoShare for patient literacy tools, e.g. information sheets, instructional videos and consumer stories • CareMonitor app to assist with insulin dose adjustment and monitoring between appointments

Services

WSD is a multidisciplinary outpatient service coordinated through the Integrated and Community Health directorate at WSLHD.

This service is focused on stabilising people with unmanaged type 2 diabetes and having them managed in the community by their GP.

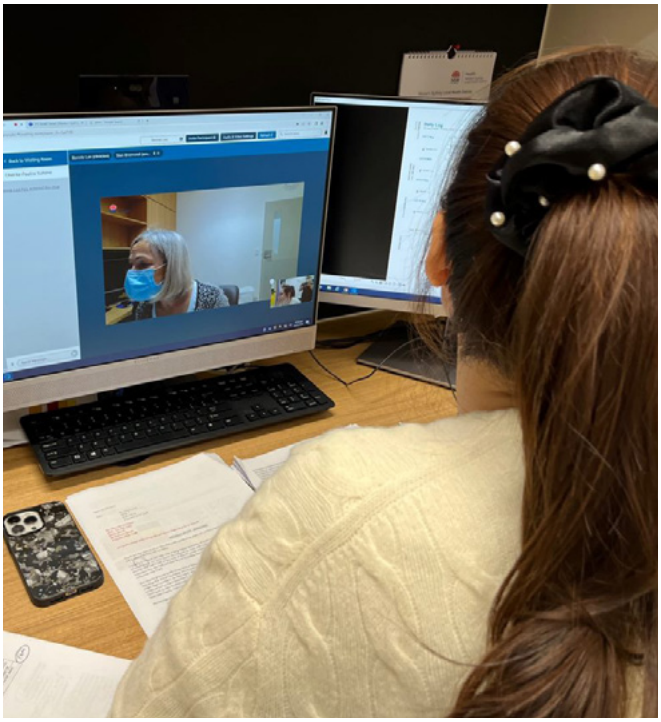
WSD provides five clinics:

- High Risk Foot Service
- Post-discharge Diabetes Clinic
- Mount Druitt Community Diabetes Clinic
- Backtown Hospital-based Clinic
- Westmead Hospital-based Clinic.

Following a referral and triage, and prior to attending the clinic, patients are provided with a fGM device that is fitted by the clinic's nurses or their local pharmacist. The patient records their glucose levels over a two-week period. This data is transmitted via an app to the clinic before their appointment. This allows the team to review this data and develop a plan prior to the case conference.

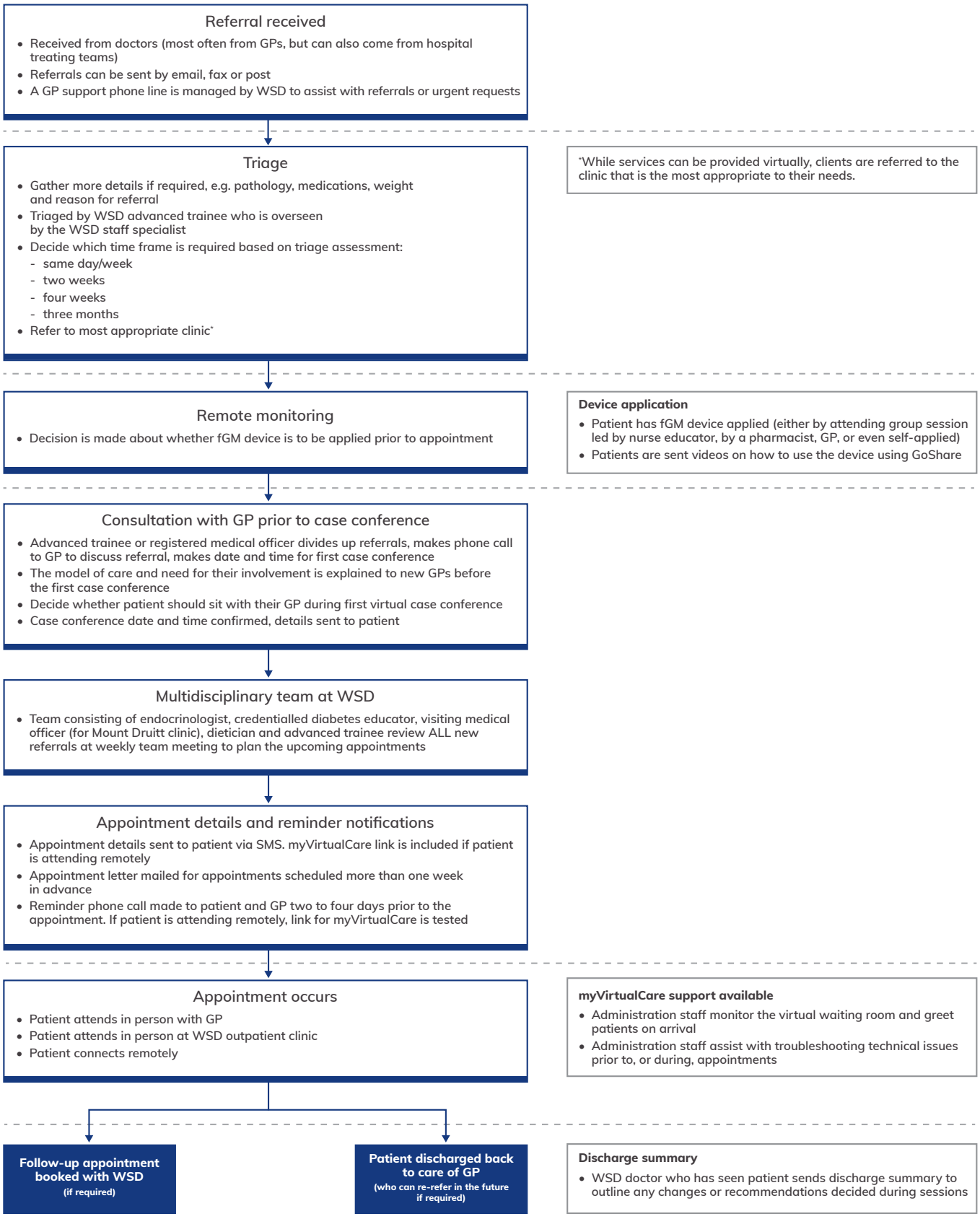
WSD provides services in-person and virtually, depending on patient preference and clinical need. The multidisciplinary approach means a range of clinicians can be involved in a patient's care whether it is delivered in-person or virtually. There are various scenarios in which patients can connect with WSD. This includes by joining their GP at their local practice to dial in for the virtual session, or the patient can join directly from home to attend the virtual appointment.

People with type 1 diabetes don't usually attend this service due to the complex nature of managing this type of diabetes. Instead, they are identified at triage and referred to alternate services to be managed by an endocrinologist.



Advanced trainee Dr Bonnie Lee talks to Sian Bramwell, a diabetes educator, in the virtual waiting room before adding a patient to the call.

Workflow diagram



Patient story

Ranjit, a 54-year-old male, attended the WSD service after his GP referred him for persistently high blood sugars. He was seen at the Mount Druitt clinic and followed up a few months later. Before the follow up in the clinic, Ranjit completed two weeks of continuous blood glucose monitoring.

Ranjit was discussed at a pre-meeting, and the WSD team developed a management plan.

During a review by the nurse practitioner at his follow-up appointment, his medications and their side effects were discussed. A plan was made for his medications. Ranjit was experiencing uncontrolled high blood glucose levels (hyperglycaemia) due to medication shortages. The nurse practitioner suggested a way to deal with this until further stock became available. After this review, Ranjit's GP was informed about the plan.

Ranjit also disclosed he was a vegetarian. This contributed to his high blood glucose levels due to high intake of carbohydrates. He was referred to the clinic's dietitian to talk about how to optimise his glucose levels with dietary control.

A plan was made to follow up with Ranjit in three to four months, once he had implemented the changes suggested by the team.

Ranjit accessed his appointments using myVirtualCare on his personal smartphone.

This is what Ranjit said about his experience:

"Initially I wasn't sure about accessing my care though the video calls, but I realised it is not that bad. I'm able to join from my car at work and it gives me privacy from my co-workers.

"It's convenient to talk to Ana [Anandhi Murugesan, nurse practitioner], this way and I don't have to come to the hospital and wait with lots of other people.

"It was so easy. I click the text and enter my details, my name and that I am a patient. I used my phone, and it has a big screen that helps me see Ana.

"I used the patch [fGM] for my blood sugar [monitoring] and found this much better than pricking my finger with the needle."

Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation. These learnings can be used by other health services in the development of local models.

Local planning, service design and governance

Local clinical governance

- Clinical governance for virtual services aligns to in-person services offered.
- The service uses ims+ to report any incidents.
- The clinics are a part of the Integrated and Community Health directorate at WSLHD. This includes reporting lines to the nurse unit manager.
- The WSD director has a direct reporting line to the general manager of the Integrated and Community Health directorate.

Processes and clinical protocols

- All patients are required to have a valid referral to access the service.
  - Most commonly, the referral comes directly from the patient's GP. The referral may be determined from their own assessment or from a community nurse recommendation.
  - If a patient has complications during an inpatient visit, the referral can also come from a treating team within the hospital network. In this instance, the patient's GP is notified either at time of referral or triage.
- Referrals are received by a central service, triaged and then people are booked into the most appropriate clinic.
- A documented pathway outlines how patients are managed through the service.
- If referrals are inappropriate or incomplete, more information is requested and a phone call is made by the advanced trainee to the referring GP.
- Prior to all virtual appointments, GP practices and patients are contacted by administration staff to confirm the appointment. The administration staff also explain how the myVirtualCare platform works and how to troubleshoot any issues.

Health pathways

- The service has two health pathways listed with the primary health network (PHN) for type 2 diabetes:
  - newly diagnosed type 2 diabetes
  - ongoing management of type 2 diabetes.
- Referral pathways on health pathways are:
  - urgent diabetes assessment and advice
  - non-urgent diabetes assessment
  - diabetes advice
  - high risk foot clinic referrals
  - prenatal and antenatal referral in diabetes
  - diabetes education and support.

Community need

- There is a diverse population within WSLHD that is reflected through the patient population of the WSD service.
- The service can have people connect either from their home or GP clinic, depending on their situation and access to stable internet connection and devices.
- Support from interpreters or Aboriginal health workers is integrated into the service where required, regardless of the modality used to access service.

Remote monitoring

- Patients are requested to complete two weeks of fGM and data collection before their appointment.
- Pharmacists, GPs and nurses at the clinic at Blacktown fit the patient with the remote monitoring device.
- Data frequency relies on patients scanning their device with a smartphone. The fGM device is usually placed on the arm. Data is stored on the smartphone in the CareMonitor app and can be set up to be transmitted directly to WSD.
- Real-time data is then available to clinicians to better understand trends and adjust treatment.
- CareMonitor was selected as the most suitable app to collect data from the fGM device by a working group of staff from the PHN and WSLHD.

Ongoing patient management

- The service is a collaboration with GPs and the diabetes specialists.
- Management and medical responsibility of patients remains with the GP.
- Following a consultation with WSD, the patient's GP is sent a letter outlining the plan discussed during the case conference. It includes details of any follow-up appointment. The GP will execute and manage this. The GP can re-refer a patient if they require further consultation with the WSD team.

The WSD multidisciplinary team reviews patients at the start of the clinic.

Health Pathways:

Health Pathways is a web-based portal designed to support primary care. The portal provides access to clinical management pathways and referral advice into local health services.

Building engagement

Key partners and stakeholders

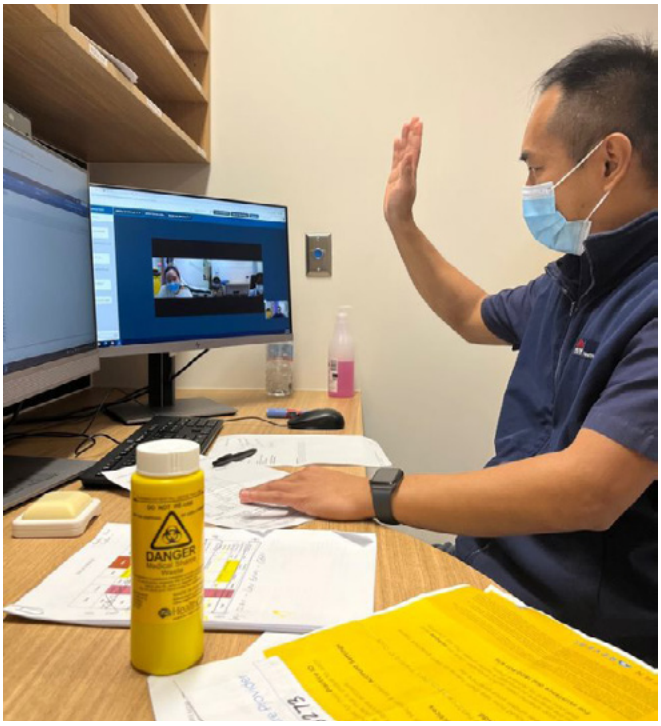
A major enabler of this model is the investment and success of the strong partnerships developed with the primary care sector, community pharmacists and multidisciplinary team.

Primary health network

- Significant time was spent connecting with the PHN in the area to establish links with practice managers and to promote the service.
- The local PHN is the Western Sydney Primary Health Network (Went West), who is a key partner in the delivery of services.
- The PHN assists by acting as the main point of contact for GPs.
- The PHN also holds a role on the WSD executive committee, and the chief executive officer of the PHN co-chairs the executive meeting with the chief executive of WSLHD.
- The chief executive officer of the PHN is also the co-chair of WSD and is supportive of WSD.
- The practice support and digital teams of the PHN are also consulted.

GP engagement

- The focus of WSD is to enhance the capabilities of GPs to manage complex patients in the community.
- More than 500 GPs within western Sydney are enrolled within the program.
- Virtual care allows GPs to access this support with minimal disruption to their clinical days.
- WSD contracts GPs as visiting medical officers (VMOs). The GPs complete rotations at the clinics to build their capacity to manage type 2 diabetes by collaborating with the multidisciplinary team. There are four VMOs working at a time. They complete a six-month placement.



Registered nurse Jaybee Serrano waves goodbye after a patient has joined from her GP's consult room.

- Group bookings (of four to six patients) can be arranged at GP clinics when a WSD nurse can attend in-person to facilitate diabetes education sessions.
- Several videos have been developed to train and instruct GPs on the use of continual glucose monitoring devices.
- GPs are provided with the Medicare item number that is available for participation in case conferences.
- A GP forum is held annually and has proved popular with GPs and partners to date.
- In conjunction with the PHN, WSD offers a masterclass to GPs and allied health providers in the community. These masterclasses run over eight weeks and upskill providers in type 2 diabetes management. They also enable broader networking among GPs.

Pharmacists

- WSD created a pharmacy working group to work alongside the service. The group includes hospital pharmacists and members of the Pharmaceutical Guild of Australia.
- Pharmacists are either trained on how to apply the fGM device or are already credentialed diabetes educators. These pharmacists have the skills to apply the fGM device, providing the patient with an alternative to attending the WSD clinic for that service.

Patient and carer engagement

- Patients have been actively engaged and empowered in decision making around how their diabetes can be managed in collaboration with their GP, using WSD when required.
- The service has a public facing website that provides patients with information.
- Resources are uploaded to GoShare and can be easily sent via SMS or email to patients to help them manage their diabetes or troubleshoot their continual glucose monitoring device.
- How-to guides for myVirtualCare are provided to support access to the service. These were developed specifically for the service.

Other partners

- The Health Literacy Lab at the University of Sydney provides the model for evaluating patient outcomes.
- Healthily created GoShare, a customisable content distribution platform. It enables the efficient and measurable sharing of health resources, tailored to patients' information needs.

Medicare billing for GPs

The Medicare item number **739** can be used for GPs when participating in a case conference with WSD. Up to five case conferences can be billed per patient each year. Medicare billing items are subject to change and determined by the Commonwealth Government. Check the Medicare Benefits Schedule for current information.

Workforce and resourcing

Appropriate technology

- The service uses myVirtualCare for all virtual consultations. This is a NSW Health endorsed and developed videoconferencing platform.
- WSD is set up to access patient's blood glucose levels via a fGM device and reader by Abbott Pty Ltd. The product was selected as it is the lowest cost device of this type. WSD purchase the sensor and subsidise the cost for the patient. A separate device reader is required if a patient's smartphone is not compatible.
- Selected pharmacists in the area, who are credentialed diabetes educators identified by the WSD pharmacy working group, can fit fGM sensors. There is also a clinic at Blacktown that runs weekly sessions to fit patients with the device and teach them how to scan and collect data.
- The service uses the CareMonitor app which people can download to their smartphone. It captures blood glucose levels to provide a 14-day overview of glucose trends to inform a case conference and medication overview.
- All physical clinic rooms are set up for virtual care with a webcam, audio and dual monitors.
- A larger room is available for conducting case conferences and clinics with multiple clinicians present.
- Some members of the WSD team are equipped to provide virtual care remotely.
- Clinicians are also set up with remote access and devices to enable them to work remotely as required through COVID-19.

Staffing model

- Dedicated staff work in the WSD model and all staff can provide care using myVirtualCare.
- There are dedicated administration staff who support virtual care. They conduct test calls with GP clinics and patients. They are also available to troubleshoot issues with myVirtualCare at the time of an appointment.
- The Mount Druitt clinic works with four GP VMOs at a time, who spend six months with the service.

Planning for implementation

- Implementation was planned in 2019 when myVirtualCare was in its development phase and WSD was an early adopter.
- Implementation was supported by the ACI Virtual Care Manager.
- Before COVID-19, the service was working to establish a rural project with Goulburn GPs to establish a joint service. COVID-19 impacted access and the service was able to rapidly pivot to a virtual model.
- WSD has trained key staff as myVirtualCare platform coordinators, to manage staff access to this virtual platform.
- All staff are onboarded to myVirtualCare and can use the platform confidently in a hybrid model.

Leadership and sponsorship

- WSD has strong clinical leadership. The director of the service is an endocrinologist and a champion advocate for virtual care.
- The service also has strong linkages to the leadership and general manager of the Integrated and Community Health directorate at WSLHD.

Data

- All non-admitted patient data is captured in the WSLHD outpatient management system.
- Reports can be accessed on non-admitted occasions of service and Medicare billing.
- The myVirtualCare platform usage data is accessed via the Splunk dashboard. It has capacity to report on number of consultations, average length of consultations, wait times, participants of consultations and other platform related data, including individual clinician usage data.
- At the end of the virtual consultation, all patients are provided with the opportunity to complete a patient survey where the data can be linked back to WSD.

Funding

- The service uses a combination of Medicare and activity-based funding.
- Activity-based funding is used for nursing, allied health and case conferences.
- Medical staff use Medicare for their services. It is a requirement that all patients have a valid referral to the service.
- A key factor to the success of the model is the ability for GPs in the community to bill Medicare for their involvement in case conferences.

General practitioner story

Dr Natalie Cochrane is a GP in Mount Druitt, who has referred patients to WSD and completed six months as a GP visiting medical officer with WSD. She has the unique perspective of being in the service and being a GP referring to it. Dr Cochrane believes that WSD offers streamlined care and reduces delays and barriers which better supports the person trying to stabilise their diabetes.

“GPs are good at managing chronic conditions but complications arise. Having one team working together with a patient and their family at the centre means everyone is interacting together in real time. They are in the consult together; communicating as a team. Everyone understands what’s going on and there is no miscommunication as to what the plan is. All advice is timely, patient-centred and it reduces errors," explains Dr Cochrane.

Dr Cochrane developed strong links and networks when she worked at WSD. She established good working relationships with the diabetes nurse educator, nurse practitioner, dietitian, podiatrist and endocrinologist. Those relationships continued when she returned to her GP clinic.

“No one should be doing diabetes care on their own. We’re not solo practitioners. We’re all in it together. Medical care for complex patients requires teamwork and WSD case conferencing is something that can enable teamwork," says Dr Cochrane.

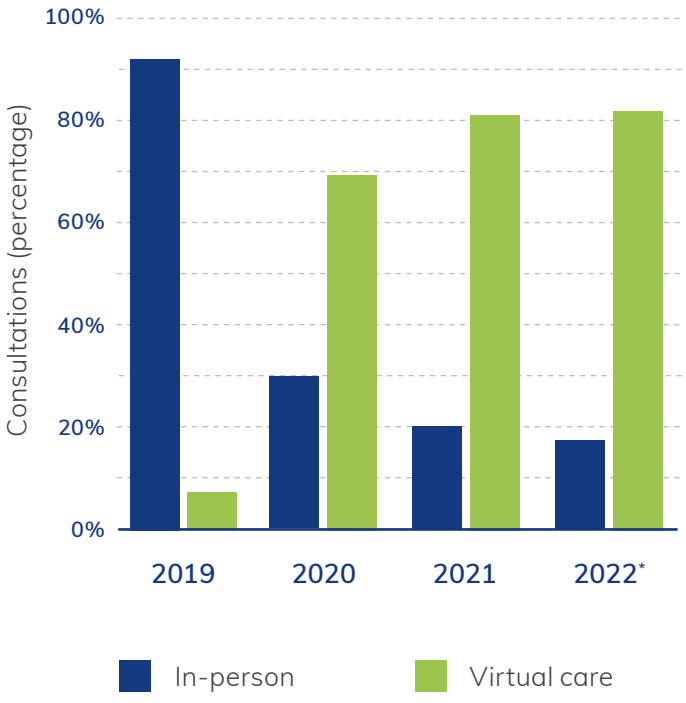
“Interacting with the WSD team with your patients is a way of ensuring that you have the best clinical knowledge. You’re confident to manage complex patients in the best possible way. The more interactions you have working as a team, helps with pattern recognition and understanding what’s available to help patients with diabetes. It improves capabilities in terms of fostering better team-based care, building confidence to make decisions and to know you can make them yourself. It’s great to collaborate and share decisions.”

Benefits of the model

Results

- Since the beginning of 2020, 15,778 virtual consultations have been undertaken alongside 4,493 in-person consultations. The chart below shows the breakdown of consultations.
- More than 500 GPs participated in a diabetes case conference in 2021.
- 85% of patients described the care they received through virtual care as good or very good.
- Every clinic within the service can offer virtual appointments.

Breakdown of in-person vs virtual care by year



Benefits

- **Access to the service saw a sustained reduction in patient HbA1c levels**
- **WSD continued to offer its full service despite COVID-19**
- **Improved continuity of care by keeping patient care with their GP**
- **Capacity building of GPs through Mount Druitt model and participation in diabetes case conferences**
- **Enhanced partnerships with primary health network and other health agencies**
- **Empowering patients to self manage through improved awareness and knowledge**

*Up until 31 July 2022.

Monitoring and evaluation

An evaluation of the Mount Druitt service has been undertaken. The aim of the evaluation was to explore the experiences and perceptions of patients and health providers, to inform the design of WSD virtual care and the new community diabetes clinic model. The evaluation consisted of semi-structured interviews with GPs and patients who accessed the service. This was followed by a thematic analysis.

The evaluation found:

- strong acceptance of the virtual model
- timely service for patients
- GPs and patients felt virtual care was acceptable and convenient
- virtual care allowed enhanced integration and learnings from joint consultations.

Work is underway to expand this evaluation beyond Mount Druitt to the broader WSD service.

The myVirtualCare platform has core functionality to automate the real-time collection of patient-reported experience measures (PREMs) for virtual care. At the conclusion of all virtual appointments, patients are directed to a patient survey, to provide feedback about their virtual care experience.

Between 1 July 2021 and 31 March 2022, 25,759 users provided feedback on their myVirtualCare experience. Of those, 1,185 responses were provided by WSLHD consumers.

Below is a summary of the results for WSLHD.

Question	Results
1. **Were you able to get an appointment time that suited you?**	WSLHD respondents reported they could get an appointment that suited them (88%), in comparison to the NSW Health combined results (85%)
2. **What equipment did you use for the appointment?**	The majority of respondents used a Windows computer (41%), followed by a smartphone (29%), Mac computer (14%), iPad (9%), or Android tablet, hospital computer and other technology (7%)
3. **Did you experience any problems with the connection or technology during this virtual care appointment?**	82% reported no issues with connection, which was just above the NSW Health combined results (81%)
4. **What problems did you have with the connection or technology?**	The key issues identified included sound (8%), connection (6%) and other technical difficulties (5%)
5. **Were you involved, as much as you wanted to be, in decisions about your care and treatment?**	90% of respondents replied that 'Yes, definitely' they were involved in the decisions about their care, which was higher than the NSW Health combined results (89%)
6. **Did the health professional/s listen carefully to any views and concerns you had?**	93% of respondents advised 'Yes, definitely' health professionals listened carefully to their views and concerns, which was only 1% lower than the NSW Health combined results

7. **Did the health professional/s explain things in a way you could understand?**	97% of respondents advised 'Yes, always' health professionals explained things in a way they could understand, which was 1% higher than the NSW Health combined results
8. **Compared to an in-person appointment, was your virtual care experience better, about the same, or not as good?**	24% of respondents reported their care was better than in-person; 59% reported it was the same as an in-person appointment; and only 17% of respondents reported it to not be as good
9. **Overall, how would you rate the virtual care you received?**	73% of respondents rated their care as very good with another 23% rating it as good; only 2% of respondents rated it poor (1%) or very poor (1%); leaving 3% of people who reported it was neither good or poor
Note: Question 10 in the survey was optional and has been excluded from these results.	

Opportunities

The service is currently applying for funding to expand their model of care to rural services in Southern NSW Local Health District and Western NSW Local Health District.

There is also opportunity to apply this approach to other clinical specialties to allow GPs and hospital specialists to provide care with patients present.

Nurse practitioner, Anandhi (Ana) Murugesan updates a patient's diabetes medication on their electronic record.

Supporting documents

Western Sydney Diabetes website:

- brochures and documents
- videos
- year in review 2021

Glossary

CEO	Chief executive officer
fGM	Flash glucose monitoring
GP	General practitioner
HbA1c	Glycated haemoglobin blood test
PHN	Primary health network
VMOs	Visiting medical officers
WSD	Western Sydney Diabetes
WSLHD	Western Sydney Local Health District

Acknowledgements

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Helen Dick	Research Nurse,	Western Sydney Diabetes
Heloise Tolar	eEngagement and Education Manager	Western Sydney Diabetes
Jaybee Serrano	Community Diabetes Educator	Western Sydney Diabetes
Dr Rona Francisco	Endocrinologist/Diabetes Specialist	Western Sydney Diabetes
Sian Bramwell	Community Diabetes Nurse Consultant	Western Sydney Diabetes
Dr Sonali Sonali	Resident Medical Officer	Western Sydney Diabetes
Sumathy Ravi	Program Manager	Western Sydney Diabetes
Tanaja Shipley	Administration Officer	Western Sydney Diabetes
Dr Tripura Sharma	General Practitioner Visiting Medical Officer	Western Sydney Diabetes
Victoria Silvestro	Dietitian	Western Sydney Diabetes
Dr Natalie Cochrane	General Practitioner	Mt Druitt Medical Centre
Clare McGloin	Head of Department, Podiatry and High Risk Foot Service	Blacktown and Mount Druitt Hospitals

Consumers who shared their stories.

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

Our innovations are:

- person-centred
- clinically-led
- evidence-based
- value-driven.

aci.health.nsw.gov.au

NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Our vision is to create the future of healthcare, and healthier futures for the people of NSW.