Join Diabetes Case Conferences

Let's work together to share the care of patients living with Type 2 Diabetes

Western Sydney Diabetes (WSD) is inviting you as a General Practitioner in the Western Sydney Local Health District to join us on the Virtual Care platform when you refer a patient for better management of type 2 diabetes.

This brochure explains:

- Why we need to work together
- How to refer your patient
- Consulting together: How it works
- The benefits of working with the WSD team
- FAQs

"These case conferences have improved our patients' diabetes management remarkably and given me and them both a well-defined management plan.

It is very encouraging to be working alongside with the specialist team and being present at the specialist consultation makes the ongoing follow up very easy – much better than private specialist consults.

A big thank you Prof Maberly and team. All specialists, registrars and diabetes educators are equally good and kind."

– DR SUNIMALEE FERNANDO, Quakers Hill Family Practice

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An Australian Government Initiative

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NSW GOVERNMENT

WHY DO WE NEED TO WORK TOGETHER?

The prevalence of diabetes in adults in Western Sydney Local Health District (WSLHD) is **12%**.

With about 100,000 people in our district with diabetes, potentially 1 in 5 adults attending your practice have diabetes.

Many of these patients have **undetected** diabetes because they have not had their HbA_{1C} level tested.

In addition, about **30% of adult patients visiting the practice are at high risk** of getting diabetes (pre-diabetes) and these patients need more support, education and tools to prevent progression.

Half the patients with diabetes attending General Practices in our area have HbA_{1C} levels greater than 7%. This is when the serious complications of diabetes are progressing.

Keeping up to date with rapid changes in diabetes management can be challenging for GPs. There are great advantages for patients to use more recent medications to help with weight-loss, prevent hypoglycaemia, protect hearts and kidneys, and give better glucose control.

When we see patients together in a Diabetes Case Conference (DCC) you improve your knowledge of best practice diabetes management based on latest guidelines. This will give you skills and confidence to manage even your most complex patients.

HOW DO YOU JOIN IN?

WSD uses NSW Health's **myVirtualCare** platform.

We have a **myVirtualCare support team** who can help you, your practice and patients to easily overcome any technical issues to make it an easy and enjoyable experience.

You and your patients can be seen on a computer with a camera, a tablet or a phone and there is no need to download any software. **Just click on the link we send you and follow the prompts to enter the waiting room and we will start the consult.**

This platform allows us to bring patients into a virtual waiting room. When you, the GP, arrive, we all move into a 30 minute virtual consultation.

It is very important we start on time.

We can also look at results such as *Flash Continuous Glucose Monitoring (FCGM)* reports, send patients' links to self-management videos and other materials.

A Diabetes Case Conference lowers patients' HbA_{1C} on average by 0.9% after three months and the benefit lasts more than three years.

WE HAVE TWO TEAMS!

There are two teams in WSLHD involved in Diabetes Case Conference (DCC) for type 2 diabetes – Blacktown and Mt Druitt Hospitals (BMDH) and Westmead Hospital (WH).

These are delivered differently by each team which means we can provide a variety of options.

The team you would usually engage with is the team closest to your practice location.

BLACKTOWN AND MT DRUITT HOSPITALS TEAM

Diabetes Case Conference (DCC) is the best way for us to start working together.

This is an expedited service and most patients will be seen within a month, with urgent cases within a week.

This first Virtual Care (VC) appointment is run as a joint case conference for which GPs can bill as case conference item number 739 (see FAQs).

All referrals for patients with type 2 diabetes to WSD BMDH are arranged as Diabetes Case Conference (DCC). The referring GP will join the virtual platform for the first consultation.

It will usually involve you, your patient, a Hospital Specialist, and a Credentialled Diabetes Educator.

With an investment of just **30 minutes of your time**, we will analyse the main issues and agree on a shared management plan.

Follow-up appointments with the patient can be carried out either over VC, face-to-face (F2F) or a hybrid of both, as needed. As the GP, you are welcome to join these subsequent sessions via VC, but it is not compulsory.

The patient will be discharged back to your full care as soon as possible with the option to re-refer if complications arise.

If you're unable to join us in a Diabetes Case Conference (DCC) we will schedule patients into our F2F clinics, but be aware there is a longer waiting list (usually within 6 months).

All clinics are set up with Virtual Care capabilities so when we need to contact you about the management of your patients, **expect a call from one of our doctors**. You will have the option to talk with us on the phone or via the VC platform.

As we all get more comfortable with VC, we believe you will appreciate it is safer and more effective if we can see each other and include the patient.

Patient ratings of the care they received through WSD VC (n=273)

You can see from our patient satisfaction survey results above that patients reported high satisfaction with VC in a Diabetes Case Conference.

You can also see from the table on the next page that consultations can be arranged on most days of the week. If our clinics will not work with your schedule you can talk with us about a special arrangement.

We are keen to make this work for you and your practice.

BOOK WITH OUR WSD BMDH ADMIN

You can send your referrals via email, fax or contact our Administration Team as listed below:

Email: wslhd-wsdiabetes@health.nsw.gov.au

Tel: (02) 8670 0082

Fax: (02) 9851 6146

www.westernsydneydiabetes.com.au

WSD has a GP Register so if you have had a successful VC Diabetes Case Conference (DCC) in the past, we will assume you or your practice staff will be ready to confirm a booking for subsequent patients.

If you have not participated in a VC Diabetes Case Conference (DCC), one of our Doctors will call you, the GP, to answer any questions.

BMDH Type 2 Diabetes Clinic Times

Location	Time Period	Type of Clinic	BMDH Clinical Team	Mode Delivery Options
Mt Druitt Hospital Diabetes Centre	**Monday** 9:00am,12:00pm	Complex T2D	Dr Michael Daytner Registrar CDE	VC F2F
Blacktown Hospital, Education Building Integrated Care	**Tuesday** 9:00am, 3:00pm	Complex T2D	Dr Rajini Jayaballa Registrar/ RMO CDEs Care facilitators	VC CDE at GP Practice
Blacktown Hospital OPD	**Wednesday** 9:00am, 12:30pm	Complex T2D	Prof Glen Maberly Registrar/ RMO CDEs Dietitian Care facilitators	VC F2F
Blacktown Hospital OPD	**Wednesday** 9:00am, 12:30pm	High Risk Foot Clinic	Dr Rajini Jayaballa Registrar CDEs Podiatrists Dietitian Care facilitators	VC F2F
Blacktown Hospital OPD	**Wednesday** 9:00am, 12:30pm	Post Hospital Discharge	Dr Rajini Jayaballa Registrar CDEs Dietitian Care facilitators	VC F2F
Mt Druitt Community Health Centre	**Thursday** 9:30am, 12:00pm	Complex T2D	Prof Glen Maberly Dr Rajini Jayaballa (alt) GP VMOs NP CDE Dietitian	VC F2F
Blacktown Hospital Education Building Integrated Care	**Thursday** 10:00am, 12:00pm	Complex T2D	Prof Glen Maberly Dr Rajini Jayaballa (alt) Registrar/ RMO CDEs Dietitian Care facilitators	VC
Blacktown Hospital OPD	**Friday** 9:00am, 12:00pm	Complex T2D	Prof Glen Maberly Registrar/ RMO CDEs Dietitian Care facilitators	VC F2F

BATCH SESSION

The WSD BMDH team can offer a 2 hour batch session for Diabetes Case Conference (DCC) on a Tuesday morning or afternoon. If desired, one of the WSD Diabetes Educators will visit the practice while the diabetes specialist joins via telehealth.

These batch sessions require 4-6 patients. We spend 30 minutes with each patient and their GP. More than one GP can be involved in a session.

If you would like to book a group of patients for Diabetes Case Conference (DCC), let us know. We may involve your WSPHN Practice Development Coordinator to help you with troubleshooting the process.

"I have lost over 10kgs and my blood sugars are now at proper levels. I am very grateful for the wonderful support from the team at the Mt Druitt Clinic."

– PATIENT, Mt Druitt Community Health Centre Diabetes Clinic

WESTMEAD HOSPITAL TEAM

A video or telephone Diabetes Case Conference (DCC) booking can be made for the Westmead team either as a single booking or a batch booking.

An endocrinologist and diabetes educator will join you and your patient on the Diabetes Case Conference (DCC). Depending on clinical need, a follow-up may be organised for further Diabetes Case Conference (DCC).

Clinic times are available on Tuesdays and Thursdays with Dr Cecilia Chi.

BOOK WITH OUR WSD WESTMEAD ADMIN

You can send your referrals via secure email or fax or contact our Administration Team as listed below:

Email: wslhd-ich-wsdwestmead@health.nsw.gov.au

Tel: (02) 8890 8168 or 0427 747 390

Fax: (02) 9687 0462

www.westernsydneydiabetes.com.au

You may also book your batch Diabetes Case Conference (DCC) via your Western Sydney Primary Health Network (WSPHN) Practice Development Coordinator, the WSPHN Help Desk on **(02) 8811 7117** or via email support@wentwest.com.au

If you would like to book a patient without a Diabetes Case Conference (DCC), there are Diabetes Clinics available for GP referrals in the Westmead University Clinic Outpatients. They use the traditional referral process and the waiting list can be long. See *Health Pathways* for the details.

"I am very pleased with the service and support provided by the WSD team. It's a very good and useful service, as I have a lot of patients whose diabetes is very complex."

– DR DAVID YAP, General Practice Service, Dharruk

WHAT'S IN THE REFERRAL MATTERS!

- If your patient has been discharged from hospital and would benefit from an outpatient specialist follow-up, we may contact you for a referral. This referral will ensure you remain involved with any on-going management plans.
- Or, if you have a patient with complex type 2 diabetes and would like our help with care, please send us your **referral**.
- To help simplify the process, WSPHN Practice Support Team can help set-up a standard referral form in your clinical computer system.
- If you are using the health management platform **CareMonitor**, include WSD as part of your patient's Care Team for an easy exchange of information.

To ensure the swiftest possible care, please:

Provide the reason for the referral and the support you or your patient needs.

Include essential information: the duration of the diabetes, co-morbidities (heart, stroke, vessels, feet and eyes) and medication; and

Up-to-date key parameters: including weight, BMI, BP, pathology results (Hb and HbA_{1C}; lipid profile – fasting Chol, LDL, HDL, TG; liver function, kidney function – eGFR and ACR).

If any key clinical information is missing on the referral, our team will contact you.

WSD Endocrinologist and Staff Specialist Dr Rajini Jayaballa

General Practice MBS Item Numbers for Diabetes Case Conference (DCC)

Description	Conference time	Item No.	Medicare fee
Attendance by a medical practitioner (including a General Practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to organise and coordinate a case conference in a Residential Aged Care Facility OR a Community case conference OR a discharge case conference (not being a service associated with one to which items 721 to 732 apply)	At least 20 minutes and less than 40 minutes	**739**	$133.10

HOW CAN YOU BILL FOR YOUR CASE CONFERENCE TIME?

This item is not dependent on COVID-19 special MBS numbers and it does not matter how geographically close you are to the hospital team.

One patient can have five Diabetes Case Conferences (DCC) a year to attract this MBS item. While this may not cover all your costs, you will be helping your patients and upskilling your diabetes management.

WSLHD is subsidising the Specialist WSD team to help cover their costs.

WHAT'S IN IT FOR YOU?

By partnering with WSD and agreeing to participate in the first 30 minute VC Diabetes Case Conference (DCC) you can access additional support for your patients.

FOR BLACKTOWN AND MT DRUITT AREAS

Consultation Support Line:

If you agree to join the WSD VC service and have the first consultation using Diabetes Case Conference (DCC) then you can call the *WSD BMDH Diabetes Management Support Line* on **(02) 8670 0082** and our admin staff will connect you to our Clinical Team. You can call during working hours to discuss cases before and after consultation.

This is in addition to the Integrated and Community Health (ICH) GP Support Line for urgent referral for admission on **1300 972 915**.

Let us know how it works for you.

Flash Continuous Glucose Monitoring (FCGM) for Diagnosis, Management and Education:

Many patients with type 2 diabetes referred to us are complex, often on insulin or need an injectable. For several years we have been providing these patients with FCGM for two weeks for diagnostic, education and management insights and getting better answers faster.

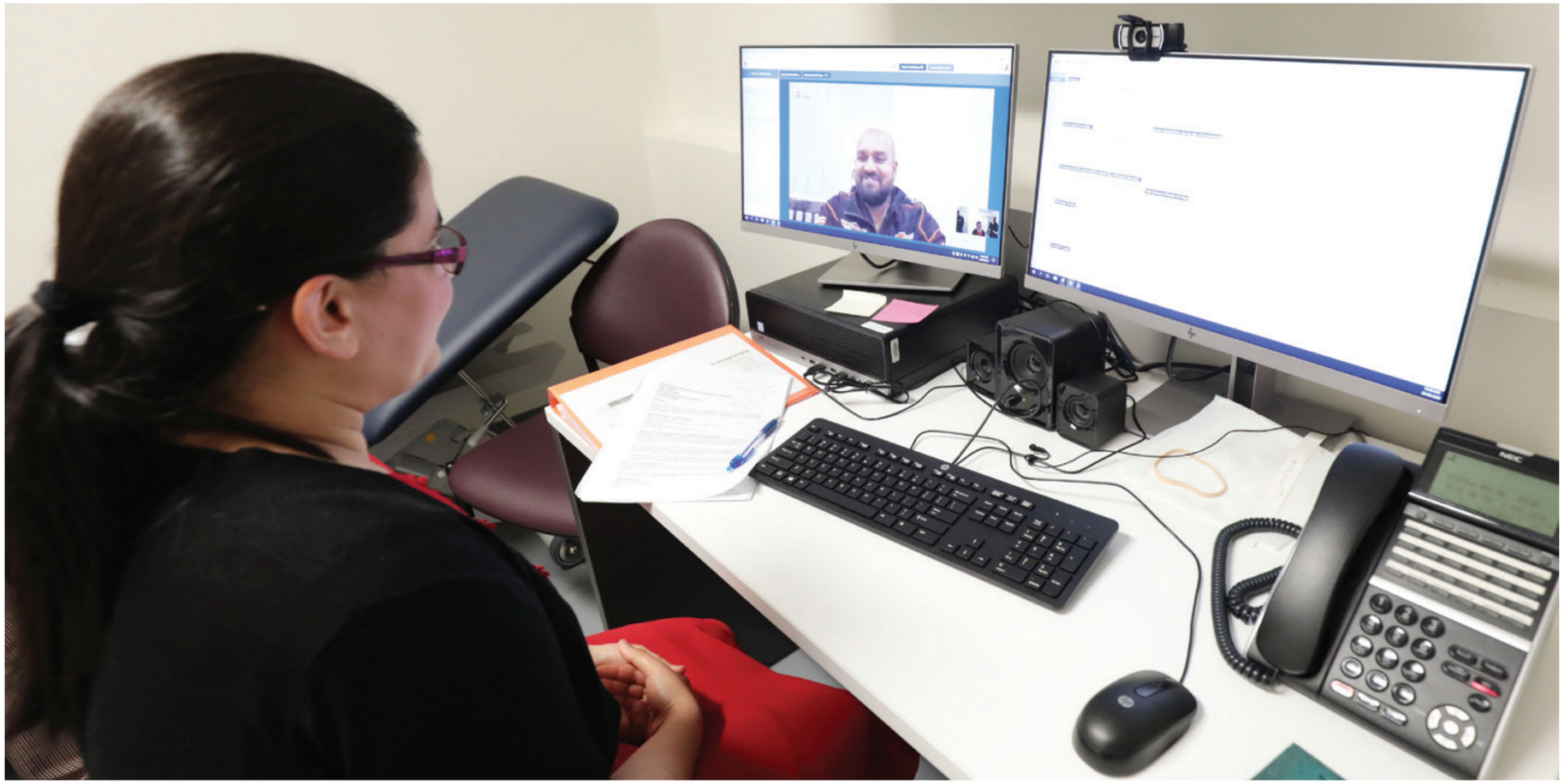
This has been a free service to your patients. We have now partnered with Abbott Diabetes Care, Australia, which will make FCGM available to your patients on insulin and naïve to FCGM.

Understanding the best use and how to interpret these results requires some learning and experience. Once a month in 2021, we are offering evening education sessions for GPs, Practice Nurses, Dietitians and Pharmacists to learn to use FCGM in the most effective way. It is especially beneficial if you can link a Dietitian into the team after a FCGM.

Learn with us about this new technology.

Stabilisation with Diabetes Educator through Weekly Insulin Dose Adjustment:

Patients often have their medications changed or start a new medication during a joint consultation. Some patients benefit from a weekly review of their blood glucose levels with the Diabetes Educator either by phone or through a smart phone app. Insulin doses are titrated up or down under a given protocol. Patients benefit from and appreciate the regular contact, which usually results in a quick improvement in glycaemic control and early identification of any issues.



Blacktown GP Dr Aajuli Shukla talks to a patient over telehealth

"These sessions are not only useful for the patient I refer for specialist input, but also provide a unique opportunity for me to learn new diabetes management principles to apply to other patients I see in my practice."

– DR ANNE TRANG, Riverstone Family Medical Practice

Patient Education Bundles:

WSD's clinical team has developed 100 short (1-3 minute) educational videos on diabetes management for patients. All videos were developed in collaboration with the Health Literacy team at Sydney University. Each video has supporting fact sheets from reputable sources such as the NDSS to create a 'bundle' of information. These bundles are available through the National Australian Diabetes Centres Patient Education Resource Library (NADC PERL) or the GoShare platform (https://healthily.com.au/goshare/).

They are easy to send and watch, and are delivered to patients via email or mobile phone.

Mt Druitt Community Health Centre Diabetes Clinic:

The clinic is a new model of care where a GP VMO is part of the team providing specialised care together with an Endocrinologist, Diabetes Transitional Nurse Practitioner, Diabetes Educator and Dietitian. Patients are reviewed both F2F and via telehealth by a multidisciplinary diabetes care team. The referring GPs are a key part of the care team and they are encouraged to join via telehealth during patient's initial clinic appointment. Our aim is to deliver value-based specialist care in the community to reduce the diabetes burden of disease through capacity building of primary care providers such as yourself.

If you are interested in working for the WSLHD as a GP VMO and feel you would benefit from spending Thursday mornings doing in-depth diabetes management for six months, please let us know.

CareMonitor – Diabetes:

WSD has partnered with CareMonitor, a health management platform,to make a patient-centred diabetes education app and shared care platform. This will enable effective and real time communication between a patient's care team members (i.e. GP's and WSD team) and help patients improve their self-management. If you already have CareMonitor or are interested, let us know.

Pencat Audit and Recommendation:

Let's work together to improve the management of type 2 diabetes in your practice by analysing the diabetes management of your practice population. The WentWest

Community Diabetes Nurse Consultant Sharon McClelland with Blacktown GP Dr Abu Kabir

team has worked with many practices so you have access to an Audit Tool for Clinical Management Systems call PENCAT. We have worked with PHN to develop a Diabetes Audit for PENCAT. If you run this, we can help you interpret the audit and make suggestions on how to improve diabetes management in your practice. This is especially relevant to practices that have joined the Collaborative Commissioning program.

FOR ALL GPS IN OUR WSLHD CATCHMENT

myINTERACT – Resource Library:

This app allows GPs to easily access eLearning activities in their own time. Once registered, Masterclass presentations and other educational events are easily accessible. Register at: https://rego.interact.technology/wsd/

Discount on National Diabetes Association of Diabetes Centres' (NADC) Diabetes Provider Course:

The agreement between the WSLHD and NADC enables General Practice clinical staff to enrol in this high quality three month diabetes course at a heavily discounted rate. Participants are issued a Certificate of Completion that can be used as evidence for their continuing professional development.

Diabetes Forums:

WSD runs evening Diabetes Forums on key management issues. You will be invited to join the Western Sydney Diabetes Clinical Forums. Register on **myINTERACT** to take advantage of these valuable opportunities.

Diabetes Masterclass:

It's free to register for this premium annual Masterclass Series which encompasses more than 15 hours of educational sessions. These are recorded and available as a resource tool. WSD collaborates with a number of partners to add richness to the educational content. We have the series assessed as an Accredited Activity for GPs – previously known as Cat 1 points.

WSD Alliance Events & Working Groups:

The Alliance is a collaboration of 140 western Sydney organisations aiming to improve the environment in terms of food, physical activity and urban planning. Working groups have arisen from the Alliance pursuing projects including greening, food policy and exercise resources.

GPs work with the WSD team in a Diabetes Case Conference

Healthy Living Options:

This is a publication that provides a range of local and inexpensive exercise alternatives that health professionals can use as a handy resource for their patients. They can be found on our website. A new edition relating to affordable food options is now available.

HealthPathways:

HealthPathways is an online tool for clinicians with an emphasis on primary care. The pathways are maps of local health services and resources (including publicly-funded services).

Visit: https://westernsydney.communityhealthpathways.org/

Login: health

Password: w3stern

Research:

WSD regularly conducts research projects including GP practices, and we encourage GPs interested in research to get involved. We have several ongoing research studies including randomised controlled trials into CGM, very-low calorie diets, and our diabetes mobile application. We also conduct research into diabetes testing in general practice, and have other investigations we would be happy for you to join.

Email our research manager Gideon by email on Gideon.meyerowitzkatz@health.nsw.gov.au if you are interested.

ABOUT DIABETES IN WESTERN SYDNEY

WSD aims to increase the proportion of the healthy population living in our district. We want to work together with our partners to slow down the progression of people getting diabetes and prevent and reduce health deterioration and devastating co-morbidities from diabetes.

- **31% of Australian population have BMI >30**
- **12% of adults in WSLHD community with diabetes**
- **30% of adults attending ED or General Practice with pre-diabetes**
- **18% of adults attending ED or General Practice with diabetes**
- **21% of adults in Blacktown Hospital with diabetes**
- **Cost of patients in hospital with diabetes 1.7 times higher than patients without diabetes**
- **Culturally diverse populations have 2-5 times higher risk of diabetes and higher risk of serious complications**

The average annual cost of a patient with type 2 diabetes in western Sydney is $16,124/yr. With 91,500 people with diabetes in our district of 1 million people, this amounts to $1.48 billion/year.

- In the WSLHD, 65% of patients with diabetes attending GPs have poor glycaemic control (HbA_{1c}>7%)
- One in five adults attending your practice has type 2 diabetes, yet less than one in 10 has been diagnosed
- More than half the adult population is at high risk for diabetes and if they lost 2kg in weight, 30% would not get diabetes.

Many new superior medications have emerged on the market.

Our research has shown only 7% of patients are on the new class of oral medication SGLT2 inhibitors that is known to help with weight loss and protect hearts and kidneys from the serious complications of diabetes.

About 15% of patients with diabetes are still taking *Sulfonylurea*, the old class of oral medication that is known to promote weight gain and cause hypoglycaemia.

The first injectable diabetes medication used by most GPs in type 2 diabetes is still insulin, rather than the most effective weight reducing medication with both cardiac and renal protective properties, GLP-1.

We have produced a comprehensive description of the services we offer. See *2020 WSD Year-In-Review* and our website www.westernsydneydiabetes.com.au

FREQUENTLY ASKED QUESTIONS (FAQ)

Q: How is a Diabetes Case Conference (DCC) organised?

A: For a single Diabetes Case Conference (DCC) send a request in the form of a referral to either WSD, BMDH or WH teams. The WSD Administration team will contact the practice to arrange a suitable time. If you want a 'batch' of patients to be seen in the same session then let us know. We may get your WSPHN Practice Development Coordinator involved to help you troubleshoot the process.

Q: How do I access this service and set up appointments?

A: If you have a single Diabetes Case Conference (DCC), contact the WSD Team (BMDH or WH) you usually refer to. If you want a 'batch' session (4 or more patients sequentially) your Practice Development Coordinator from WSPHN will act as a liaison between your practice and the specialist team. They will assist you with bookings and preparing and sending referrals.

Q: Who needs to be at a Diabetes Case Conference (DCC)?

A: To qualify for a Case Conference under MBS billing there needs to be three multi-disciplinary team members. Usually this is the General Practitioner, Endocrinologist (or Advanced Trainee Registrar); another allied health professional (either a Diabetes Educator, Dietitian, Exercise Physiologist or Practice Nurse); and the patient – who may like to bring a support person, such as a spouse or family member, with them. If the patient cannot attend but gives consent for the case conference, it can go ahead. It is always better to have the patient if possible.

Q: What do I have to do to get involved with Diabetes Case Conference (DCC)?

A: You can simply give us a call to say you are interested, then send us your referrals. Our team wil contact you to organise the appointment with you and your patient(s). Please ensure your referral includes essential information and clinical parameters.

Q: Will the Endocrinologist be taking over the patient's overall diabetes care and management going forward?

A: No, not if the Case Conference is just one occasion. This single Diabetes Case Conference (DCC) will not replace normal diabetes management in your practice. It is a learning session to discuss management issues and treatment options. If the Diabetes Case Conference (DCC) is part of a clinic then the GP and the Specialist team will work out a plan on how to share management until the patient is discharged to the GP's care.

Q: How long will each case conference take?

A: Each case conference takes about 30 minutes. It is important these start and end on time as otherwise, both the GP and Specialist team cannot meet their commitments. If you cannot make the appointment time then the case conference will need to be re-scheduled. Please keep in mind Diabetes Case Conference (DCC), via VC in particular, have to be on time, to work.

Q: Will there be any cost to the practice?

A: There is no cost to the practice. As the GP, you can bill a case conference item number that is time based. As most consults last for about 30 mins, this is MBS item 739: "Organise and coordinate a case conference of at least 20 and less than 40 minutes". Please view this also as an upskilling session, not just as a reimbursable event.

Q: Will there be any cost to the patient?

A: No. Your practice will usually bulk bill the patient using the appropriate Item Number. The Endocrinologist will also bulk bill the patient for his/her time.

Q: What is the planned follow-up?

A: Following a Diabetes Case Conference (DCC), you as the GP will manage the care and assess the efficacy of any suggested change in the patient's diabetes management. If shared care is agreed for a time this will clearly be discussed at the end of the Case Conference.

Q: What if the patient already has an Endocrinologist?

A: The Endocrinologist involved in a Diabetes Case Conference (DCC) works closely with colleagues within the Western Sydney LHD. They are aware of the program and support the principle that a patient with diabetes can be best supported in the primary care setting. All recommendations provided by the Endocrinologist in regards to the patient's ongoing management are based on current clinical best practice indicators. No patient management will be changed unless all health practitioners involved in the case conference, including the patient, agree. Ongoing care will remain with the patient's usual Endocrinologist.

Q: Can the Allied Health Professional (AHP) and Practice Nurse (PN) sit in on the case conference?

A: Yes. The case conference is an opportunity for learning and sharing knowledge and encouraging a team approach. We welcome involvement from the AHP and PN.

Q: Does the patient need to be complex?

A: For maximum learning, select patients with different management issues. These can vary from early onset to those with greater complexity. The Specialist team will try and cover something different in each session. The idea is that the GP will take the learning forward to other patients with similar issues.

Q: Does my patient require a special preparation for Diabetes Case Conference (DCC)?

A: No, but it is helpful to explain to your patient/s what is involved (or what to expect) prior to his/her appointment.

The team was "very patient in listening to my issues irrespective of whether it related (or not) to Thyroid function; kindly reviewed my medications; and was very thorough in discussing issues and possible ways forward for my treatment."

– JOSHI BHARATKUMAR, Patient, Blacktown Hospital

Western Sydney Diabetes
Beating Diabetes Together

For more information about WSD please visit the website below. To speak with us, or to make an enquiry, please contact WSD program manager, Sumathy Ravi via email at **Sumathy.Ravi@health.nsw.gov.au**

Western Sydney Diabetes
Integrated and Community Health
Level 3 Administration and Education Building
Blacktown Hospital Campus

www.westernsydneydiabetes.com.au

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