Background
Dianella Community Health is a member of the Hume Whittlesea Primary Care Partnership (HWPCP).
In 2012, the HWPCP organised a forum where senior managers from a number of their member agencies came together to discuss the fact that the catchment had one of the highest admission rates for avoidable diabetes complications in Victoria.
At the forum, agencies also identified that most of them had long wait times for diabetes services.
This was thought to be due in part to general practice referral patterns – some general practitioners were referring to multiple organisations for the same services, resulting in duplication of services and longer wait times.
Member agencies agreed to work together to improve communication between service providers, and to integrate diabetes care across the HWPCP catchment.
A working group with representatives from local community health services and Northern Health was established and began working on the Improving the Coordination of Diabetes Care Project.
The working group met monthly for two years. Using an action research methodology and Plan, Do, Study, Act cycles, the group worked through strategies for improving communication and integration of diabetes care in the catchment.

What they did
Dianella along with other community health services in the catchment and Northern Health agreed to a number of system changes to improve integration and coordination of diabetes care in the catchment. These changes include:
- use of common tools across the catchment to assess diabetes risk and prioritise care
- an agreed preferred standard of general practice referral documentation
- agreement across the catchment on minimum services a client with diabetes should receive.
How each of these has been implemented by Dianella is outlined below.

Tools to assess diabetes risk and prioritise care
The Adult Diabetes Triage Tool (ADTT) is used by Intake to support categorisation (and prioritisation) of clients on the basis of their disease progression or complications.
The tool also supports intake to define the level of care required and direct clients to the most appropriate services within Dianella or a more appropriate agency in the catchment.
An agreed standard for general practice referrals
Dianella has a standard general practitioner diabetes referral form that general practitioners are required to complete. This referral form is consistent with the minimum standard of general practitioner referral documentation that has been agreed to by community health and Northern Health. This means that intake staff have enough information to complete the categorisation (and prioritisation) of clients and identify the level of care required.

Agreement on minimum services a client with diabetes should receive
Dianella has aligned its diabetes services and processes with the diabetes care pathways that the community health services in the catchment and Northern Health have agreed on.

Three care pathways have been identified: standard, intermediate and extended.

Categorisation is based on risk of disease progression and/or complications using the ADDT. The standard care pathway outlines the minimum education and services that all people with diabetes should receive, and the intermediate and extended care pathway outline the additional services or shorter timeframes for delivery of care required for those with unstable diabetes and/or complex care needs. Dianella offers the standard care pathway and as a result of the processes and agreements with other agencies is able to identify people who require additional services and facilitate a smooth transition to the most appropriate service.

Outcomes
Through the use of the ADTT at intake, Dianella has a clear process for identifying the level of care required and appropriate care pathways for people with diabetes.

The general practitioners in the area have become more aware of the appropriate service for their client. This has occurred through education and support documentation that was distributed by the Medicare Local. The result has been that general practitioners understand what service fits their client’s needs and refer directly to that service resulting in reduced wait times as clients are not being referred for duplicate services.

The agreed care pathways support consistency of care across the region and seamless redirection of referrals to appropriate services when needed.