Overview of the selected intervention in South Western Sydney

Mobile and web based intervention to improve access to primary care for patients with type 2 diabetes

Rationale: A significant proportion of people within south western Sydney are living with a chronic disease. This places increased demand on primary health care and acute care sectors. The prevalence of diabetes in Australia and in south West Sydney is increasing (by 158% in SWS between 2000 and 2011). The Australian Diabetes Map indicates that 6.2% of the population of SWS are registered with the National Diabetes Service Scheme compared with 5.1% nationally. Potentially preventable hospitalisations for diabetes complications are higher in the region compared with NSW (153.9 and 139.3 per 100,000 population respectively). Also, the rate of hospitalisations for diabetes as a principal diagnosis in 2013-14 was higher in SWS compared with NSW as whole (166.1 and 151.1 per 100,000 population respectively). Diabetes related deaths in 2013 were higher in SWS compared to NSW (31 and 27 per 100,000 respectively). Some groups such as Aboriginal population, people from low socioeconomic backgrounds, people from CALD and refugee backgrounds and people with low health literacy are at even greater risk of developing diabetes and diabetes complications later in life.

Comprehensive management of diabetes requires access to a range of medical and nonmedical services, but also requires an enduring relationship with a primary care doctor who takes principal responsibility for the patient's care and coordinates services. South Western Sydney (SWS) has established urban areas, newly developing areas and rural/urban fringe areas with large geographic distances between services. In SWS, there are good attendance rates in primary care, with residents visiting the General Practitioner (GP) on average 7.5 times per year – the highest of all Primary Health Network (PHN) regions in Australia. Despite this high GP attendance rate, vulnerable populations experience barriers in the comprehensive management of their chronic conditions through primary healthcare. Concerns relate to poorer compliance with treatment and difficulty adopting healthy behaviours and undertaking self-management activities. The vulnerability of patients is their limited literacy to understand the importance of coordinated and comprehensive care, and their lack of knowledge of local resources.

The proposed intervention is to develop a web portal which provides reliable health information, access to e/m/telehealth services and local allied health and other ancillary services that are relevant to diabetes care. The portal will facilitate patient goal setting and access to the portal will be supported through the patients regular GP. The proposed intervention aims to enhance affiliation to a coordinating primary care doctor and to improve self-management skills.

Targeted population: Patients presenting to general practice with diabetes, poor health literacy, and additional social vulnerabilities, including: low socioeconomic status, geographic isolation and culturally and linguistically diverse backgrounds.

Intervention: Supported access to comprehensive and coordinated care for chronic disease in primary care through a web portal facilitating access to a range of e-Health information, telephone coaching and education programs. A program officer will provide training and in-house support to primary care practices and liaise referral services and programs.

Links with primary healthcare: Recruitment of 10 general practices in each of three geographic area and 10 patients per practice. The three areas are low socio-economic area/public housing, high migrant/refugee population area and a semi-rural housing development area. General practices will be

recruited through the Primary Health Network. Patients will be invited to participate as they present to the practice and via mail from the practice.

Local Innovation Partners: Primary Health Network, Local Health District (State funded hospital, community Health services), University of New South Wales. Other partners involved in deliberations and intervention includes: Local diabetes association, Refugee Health Service, Aboriginal Medical Service, Local government.