5. Diabetes Model of Care

The Diabetes Model of Care provides a framework for comprehensive, accessible and efficient provision of coordinated diabetes prevention and management services for all Western Australians.

The key objective of the Diabetes Model of Care is to ensure that diabetes services are optimally configured to:

- Prevent or delay the onset of diabetes
- Prevent and slow progression of diabetic complications, especially heart disease, renal failure, impaired vision and lower limb amputations
- Improve the quality of life of people who have diabetes
- Reduce inequities in diabetes service provision, particularly for Aboriginal people and other disadvantaged groups

Additional objectives include reduced frequency of diabetes-related presentations to hospital emergency departments, lower rates of hospital admission, shorter length of stay and better outcomes for people with diabetes.

The Diabetes Model of Care addresses the following stages of diabetes prevention and management:

- Community awareness and prevention.
- Prevention and early diagnosis in high-risk groups.
- Optimal initial and long-term management.
- Early detection and optimal management of complications.
- Coordinated prevention and management of acute episodes.

The Model of Care for each stage of diabetes consists of the following components:

- Health promotion
- GP-coordinated multidisciplinary prevention and management, including targeted programs for high-risk and vulnerable groups
- Specialist team services

The roles of these services for each stage of diabetes are summarised in Table 3 and described in more detail in the following sections.

Detailed recommendations for implementation of each stage of the model are listed in Section VII. These are preceded by a summary of eight key priorities and related strategies which apply across multiple stages (Section VI, Table 4).
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<tbody>
<tr>
<td>General Population</td>
<td>At Risk of Diabetes Un-diagnosed Diabetes</td>
<td>Newly Diagnosed Diabetes</td>
<td>Established Complications</td>
<td>Acute Episodes</td>
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**Health Promotion**
- Awareness
  - Promotion of healthy environment & lifestyle (WAHPSF 2007 – 2011)
- Awareness of risk
  - Importance of early diagnosis
  - How to reduce risk
- Promotion of healthy lifestyle
  - Importance of weight loss, diet exercise
  - Need for complications screening

**GP – Coordinated multidisciplinary prevention & management**
- Awareness
  - Promotion of healthy lifestyle
- Patient Information
  - Risk assessment
  - Community based risk reduction activities: diet exercise, weight loss
- Patient Information
  - Initial assessment
  - Personal plan, targets for weight, exercise, BP, lipids, smoking cessation
  - Self-management education & support
  - Medication
    - Glucose control
    - Reduce CV risk
  - Regular complications screening
  - Specialist referral
  - Specialist referral of complex, difficult cases
- Targeted Complications Screening & Management for High Risk Groups
  - Target services for high risk groups

**Targeted programs for high risk, vulnerable groups**
- Targeted diabetes detection programs

**Specialist team services**
- Type 1 care
- Assessment of complex cases, intensified treatment
- Complications screening
- Insulin stabilisation
- Paediatric service
- Pregnancy services
- Outreach services
- Service planning, coordination
- Research

- Complications screening & monitoring
- Intensified diabetes treatment, cardiovascular risk reduction

**Support Service Coordination**
- WA guidelines
  - Decision aids
  - Local protocols
  - Local resource directories
  - Diabetes care groups
- Care plans
- Commonwealth quality initiatives
- Accessible advice
- Clinical review
- Inpatient diabetes management
- Management of advanced complications
- Outreach services
- Care plans
- Commonwealth quality initiatives
- ICT data sharing, communication & resources
- Local & statewide registers
- Recall systems
- Audit