Multidisciplinary Approach to Diabetes Care (MADC)

ACT PHN project update — model of care, engagement, and patient-reported outcomes

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Allied Health Engagement Officer / Project Lead

Today's focus

- Why MDT for diabetes in primary care
- Model of care + patient journey
- Engagement & activity tracking
- PROMs: QoL, Diabetes skills literacy
- Integration learnings + next steps

Acknowledgement of Country

"I acknowledge the Ngunnawal people as the traditional custodians of the land on which we meet today and pay our respects to the Elders past, present, and emerging. I also extend that respect to any First Nations people joining us today."

"Sunrise to Sunset" artwork by Sarah Richards was created to reflect CHN's cultural journey to date and their Cultural Competency Framework (CCF). See our website for more information.

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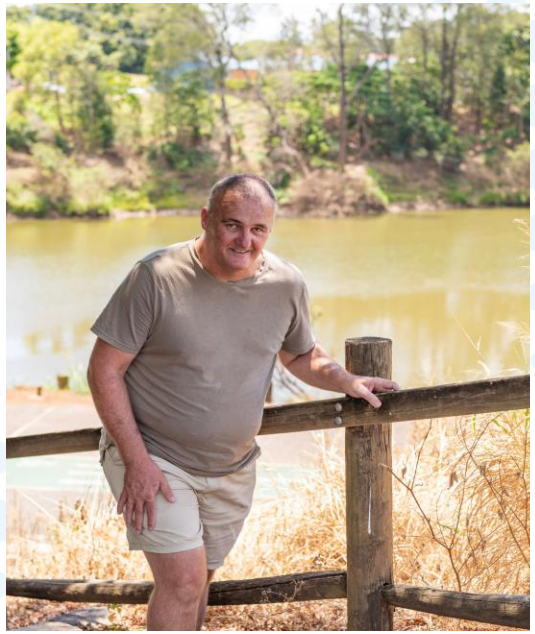



Prevalence

- Fastest growing chronic condition in Australia
- 1.5 million Australians living with diabetes
- Type 2 accounts for 85-90%
- 300 Australians develop diabetes every day
- Driven by risk factors, lifestyle factors and an ageing population

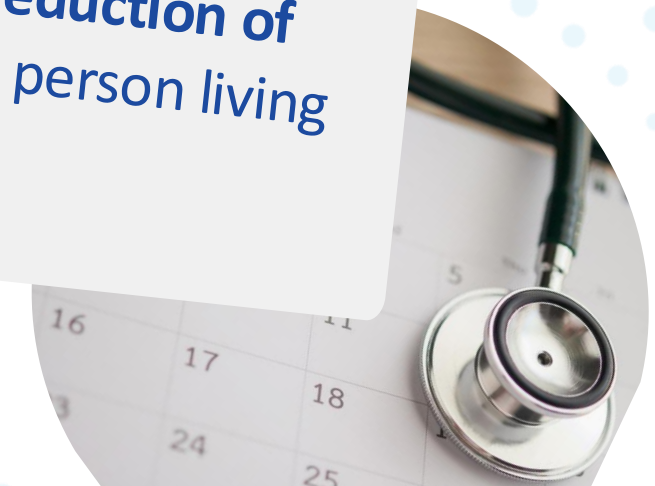
Multidisciplinary Care Matters

Multidisciplinary care is critical because:

- Diabetes is **complex**, affecting multiple organ systems.
- Requires a **combination of medical, behavioural and lifestyle interventions**.

Team-based care works because each discipline addresses a different aspect of diabetes management.

Leads to **better health outcomes;** more **support** and a **reduction of complications** for the person living with diabetes.



Why a multidisciplinary approach for diabetes?

Problem we are addressing

Adults living with diabetes often face barriers to allied health support (cost, access, local availability)

This project tests a **comprehensive** and sometimes co-located **MDT model** to **improve access, coordination**, **patient experience**, and **outcomes**.

What is “good” MDT care?

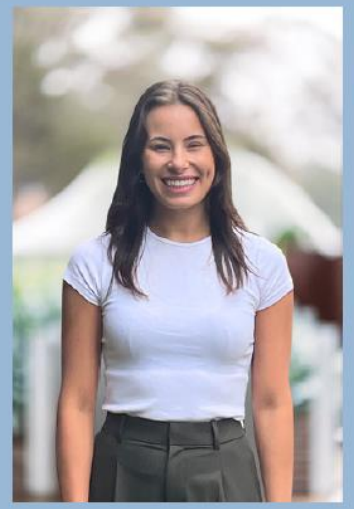
- Right care, right place, right time
- Shared goals
- Clear roles
- Effective communication
- Mutual trust
- Patient enablement (knowledge, skills, confidence)
- Measurable outcomes (PROMs + service activity

Five principles for effective team-based care (RACGP)

Who is in the MDT?

Eligible adults with diabetes may be referred if patients of: **Conder Surgery** (south), **Gunghalin Medical & Surgical Centre** (north), and newly joined **Waramanga Medical Centre** (central south).

Allied health services may be co-located, at AHP centres, via Telehealth, or at-home (ad hoc).



ACCELERATE PHYSIOTHERAPY

Canberra Allied Health

EQUIPD ALLIED HEALTH & COMMUNITY GYM

diabetes australia

THE WALKING CLINIC PODIATRISTS

Find out more

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Project design

Aim

Explore how a MDT model can be operationalised within small general practices – with mechanisms to support collaboration and access to allied health services, and contributions to improve patient outcomes and health literacy.

1) Co-design + onboarding

- **Scoping needs** and **QI data**
- Early discussions with **peak bodies** such as **IAHA, APA, APodA, Dietitians Australia, Health Care Consumers Association**
- Co-design consultations with the **Allied Health Professions Australia**
- Focused **co-design workshops with commissioned providers**
- IAHA **Cultural Responsiveness** training
- Program **team meetings**
- **Shared** templates, MADC logbook
- **Communication channels** - HealthLink

2) Activities

- Eligibility, triaging, **case coordination**
- **CCM Referrals** from GP/practice nurse
- **HbA1c** tracking at general practice
- **Data** collection (demographics, **PROMs**, **Diabetes Skills**)
- Allied Health **assessments** (allied health sites)
- Patient **coaching**, **education**, **re-enablement**
- **HealthLink** + MADC **Teams channel**
- **Case conferencing** + **online huddles**
- **MADC Logbook**
- Program **progress meetings** (quarterly)
- Bi-annual **Stakeholder Meetings**
- Continuous **quality improvement**

3) Program evaluation

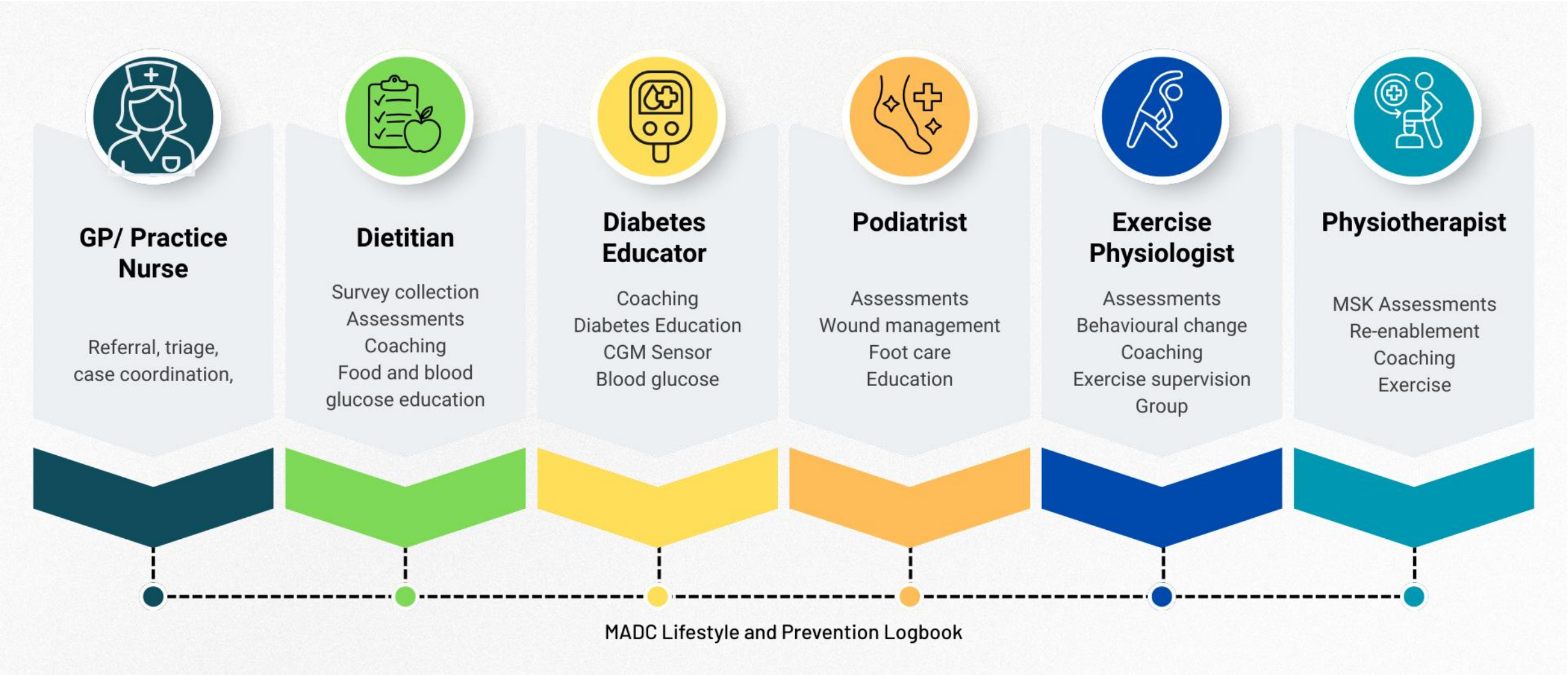
Patient-level data:

- Demographics
- EQ-5D-5L Quality of Life (PROMs)
- Health Literacy: LMC Diabetes Skills

Provider-level data:

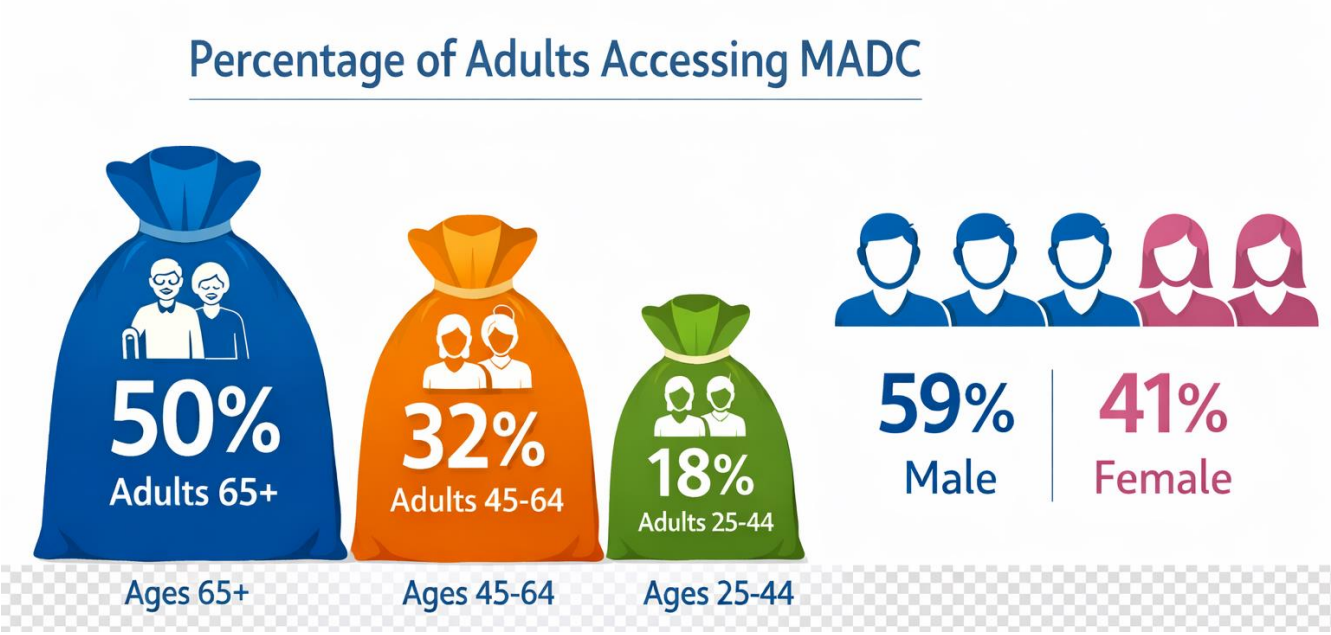
- Engagement Tracking
- Case studies
- Good news stories
- Provider experience surveys

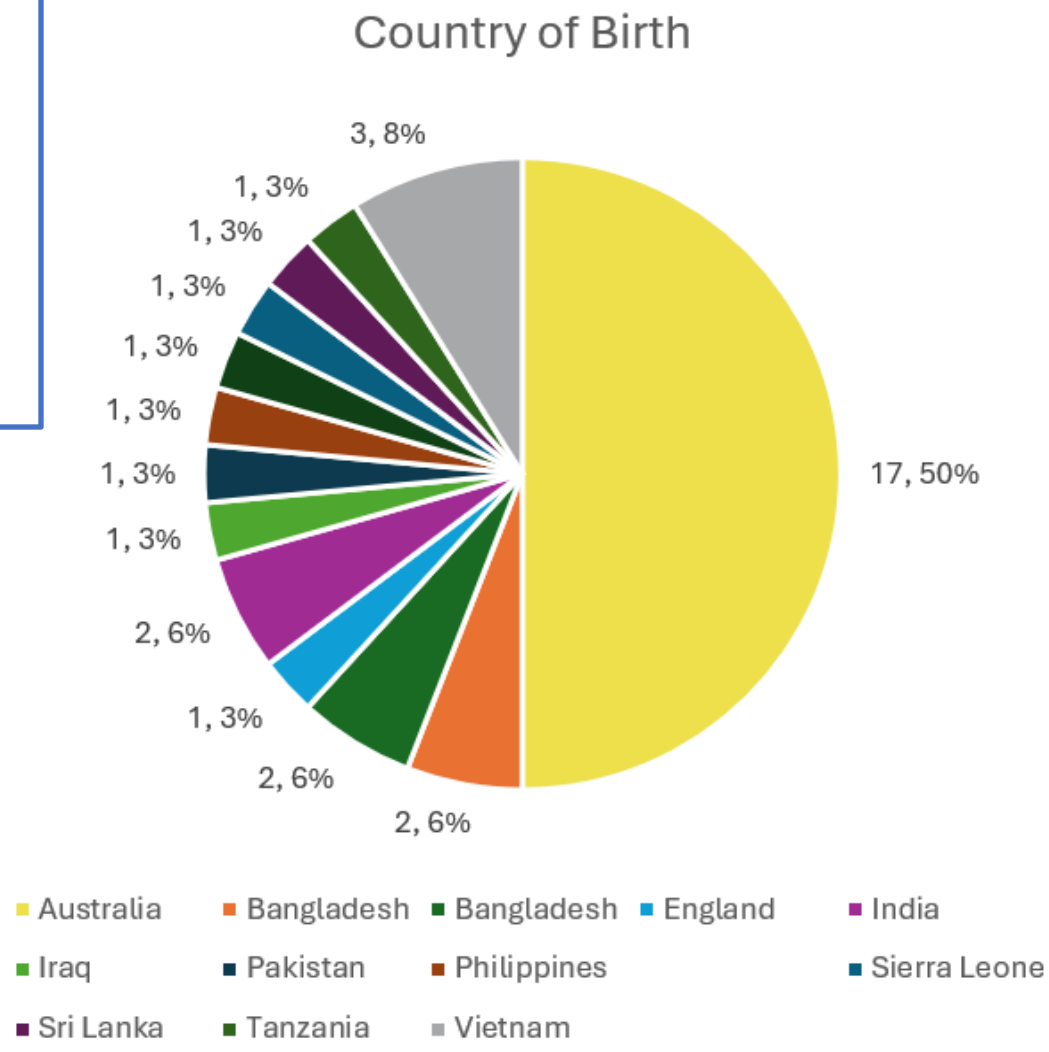
Multidisciplinary Approach to Diabetes Care (MADC)



Data collection (Aug – Dec 2025)

- **Demographics**
- **PROMs:** EQ-5D-5L (baseline + > 3-months or exit)
- **Health literacy tools:** LMC Diabetes skills
- **Surveys:** Provider experience, good news, case study
- **Quantitative reporting**: Patient engagement





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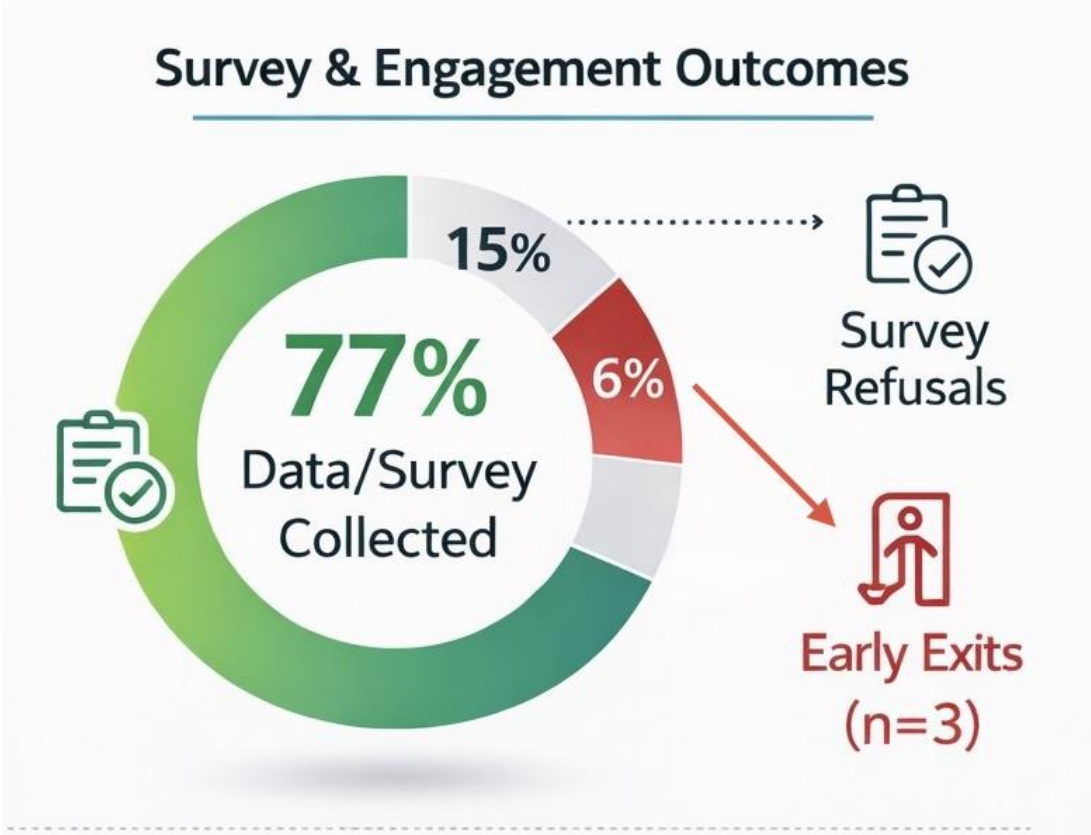


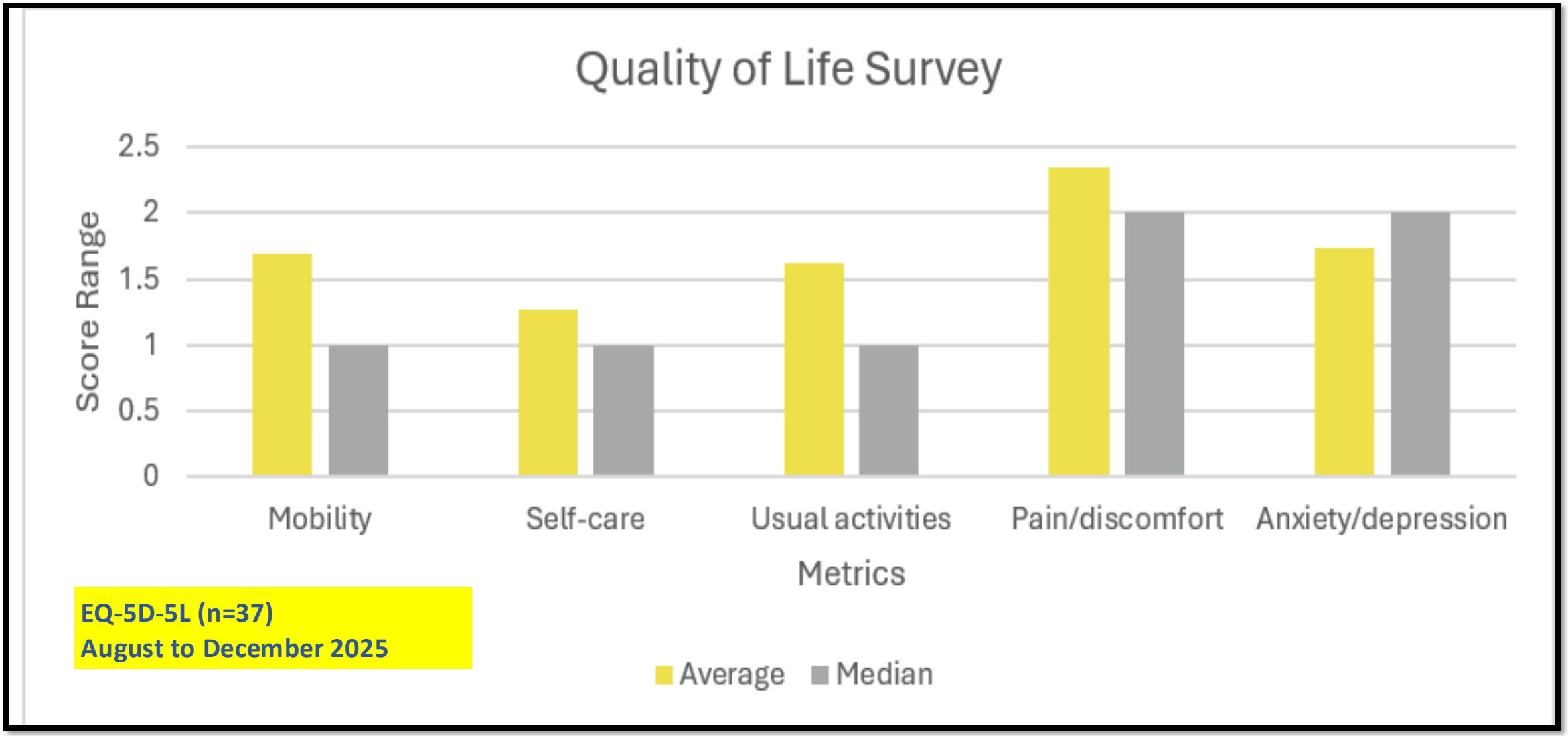
51 Patients Referred

100% Consent Received

77% Data Collected

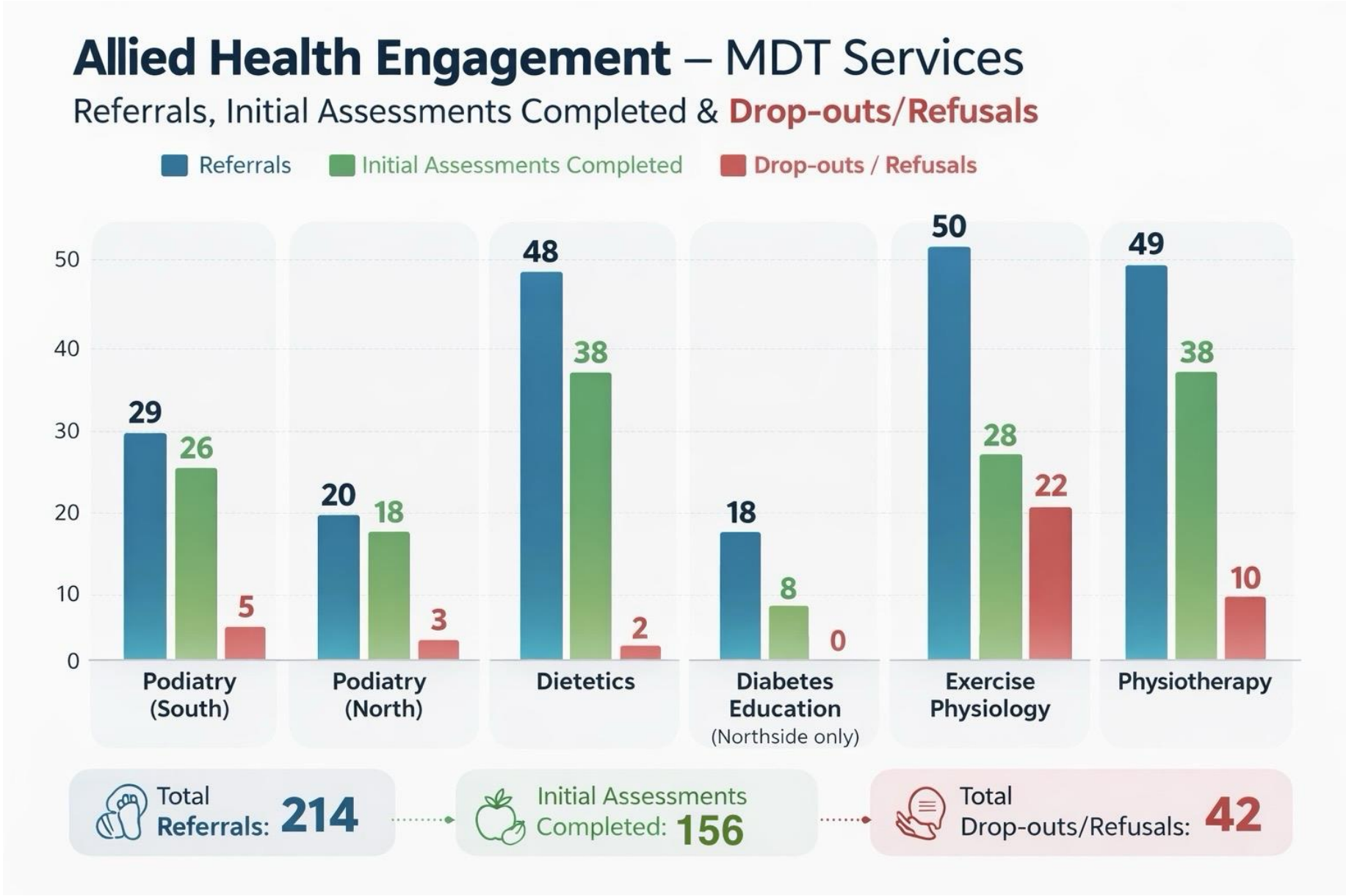
3 Early Exits

Data collection (Aug – Dec 2025)



EQ-5D-5L (n=37)
August to December 2025

Data collection (Aug – Dec 2025)



What we collect and measure – Provider Implementation Survey (2025)

Successes

- Strong patient engagement and positive patient feedback
- Effective multidisciplinary collaboration across providers
- Improved access to allied health for participating patients
- Flexible care delivery including telehealth and home visits
- Case conferencing and shared tools supporting coordination

- Case conferencing and shared tools supporting coordination

Challenges

- Communication and referral flow issues (Healthlink, missed referrals)
- Patient flow challenges, including incomplete screening or surveys
- Lower uptake of dietetics, compared with other services
- Patient barriers (travel, engagement, contact difficulties)
- Limited transition options after program completion

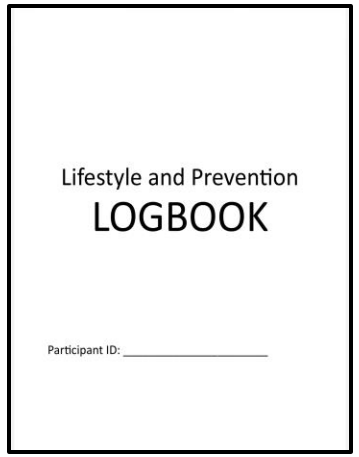
Recommendations

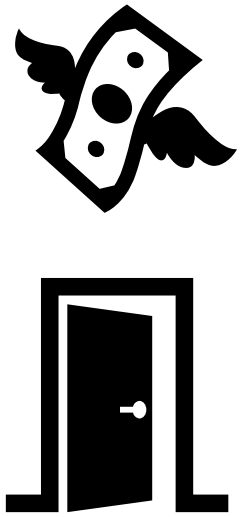
- Strengthen communication loops between GPs and allied health
- Ensure all disciplines included early in referral pathway
- Encourage earlier dietitian involvement
- Improve care/case coordination for referrals, surveys and discharge
- Expand model: additional GP practice and broader allied health involvement

Executive takeaway: Providers value the MDT model and patient engagement, but improvements in communication, referral pathways, and **coordination** would strengthen program delivery.

Addressing barriers

Consumer enablers





Provider enablers

HealthLink

Teams

Other enablers

Shared documentation

Templates, MADC Logbook, Reporting

Weekly huddles

Care planning reduces duplication
improves role clarity and scope
Fosters mutual trust

Flexible delivery

Meeting patients where needed onsite, Telehealth, monthly co-located clinics, or home visits (ad hoc)

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EQUIPD

ALLIED HEALTH

Dylan Grubb
Director / Exercise Physiologist
ESSA Chair, ACT

MADC PROGRAM

MULTIDISCPLINARY APPROACH TO DIABETES CARE

EQUIPD

- Individual Assessment & Review
- Supervised Exercise Classes
- Independent Gym Access
- Cross Disciplinary Coordination
- Accessible Service Delivery

MULTIDISCIPLINARY CARE

- General Practice Led
- Dietetics & Nutrional Support
- Physiotherapy
- Podiatry
- Diabetes Education

ACCELERATE

PHYSIOTHERAPY

WHAT WE DO:

- 30-minute initial consultation
- 60-minute group classes
- 1-on-1 physiotherapy (MSK conditions)

Adnan Asger Ali
Director / Physiotherapist
APA, National Chair – Musculoskeletal

CONDITIONS BEING TREATED

Examples of Conditions Being Treated by Physiotherapy in the MADC Program

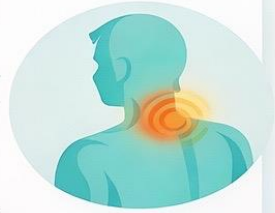
1. LOW BACK PAIN

- A common injury
- Often stems from a prior back injury where exercise was not followed through
- Strengthening takes 3-6 months

2. OSTEOARTHRITIS / KNEE REPLACEMENT

- Common in older adults with knee osteoarthritis
- Focus on strengthening surrounding muscles to relieve knee strain
- Manage weight and diabetes alongside joint health

3. CHRONIC CERVICAL / THORACIC PAIN



- Slower progression due to higher pain levels
- Requires manual therapy and education on pain management
- Starts with 2-3 home-based exercises for stress relief

Good news stories and case studies

Good news story

Physiotherapy: Patient X (T2DM) and recent Total Knee Replacement (TKR) was reducing physical activity. Manual therapy and individualised exercises improved capacity for physical activity. This resulted in a regular exercise regime to aid in muscle strengthening and weight management to improve diabetes - 10 wks group exercise with individual program.

Diabetes Educator: Client presents with no understanding regarding medication Family history of Diabetes Suboptimal management of diabetes. Does not want to be on medication. Discussed how medication works and how Type 2 diabetes is a progressive condition. Continuous Glucose Monitor attached and worn for 2 weeks. Instant access to glucose values which showed client the need to take medication and how low GI carbohydrates and exercise can impact on glucose. Behaviour change and taking medication has commenced. We wait to see the next HbA1c.

Case Study

Exercise Physiology: Patient Z (T2DM), 66 y.o, had low exercise capacity, MSK limitations, and limited confidence in self-management. Through a stepped MDT approach – starting with individual exercise progressing to group exercise, ultimately transitioned to independent gym participation 3x per week. He has taken advice from dietitian and CDE onboard and maintains consistent attention to foot care. Stepped care allowed him to develop knowledge and confidence to manage his condition effectively. Early outcomes show strong adherence to care plan.

Dietetics: Patient Y (T2DM), 50 y.o, presented with poor glycaemic control (HbA1c 11.6%j and a diet high in refined carbohydrates with low protein and fibre. Over 3 dietetic consults, nutrition education focused on reducing carbohydrate load, improving carbohydrate quality, and increasing protein and fibre intake. Early outcome suggests HbA1c reduction to 6% range indicating substantial improvement in glycaemic control.

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PHYSIOTHERAPY

EQUIPD
ALLIED HEALTH

What are the advantages of MADC?

WE GET TO HELP AND EDUCATE PATIENTS

WE GET TO COLLABORATE WITH OTHER ALLIED HEALTH PRACTITIONERS

CREATES AN ENVIRONMENTW HERE WE ALSO GET TO LEARN

POTENTIALLY MAKING A DIFFERENCE TO PATIENTS' LIVELIHOOD

The MADC pilot demonstrates 5 key takeaways:

1. Multidisciplinary care in small practices is achievable with the right structure.
2. Practice Nurse-led coordination with external allied health is essential to strengthen integration.
3. Digital communication platforms are enablers, not add-ons.
4. Scope clarity prevents inefficiency and duplication.
5. Patient-held tools reinforce shared accountability.

This is a potential framework for integrating allied health into primary care to improve chronic disease management.

Connect with us:

Thank you!

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