Northern Adelaide Local Health Network (NALHN) - Division of Allied Health – Intermediate Care Service

Living Well With Diabetes

Adapting Rehabilitation Models to Enhance Self-Management and Quality of Life in Diabetes

NALHN's Intermediate Care Service (ICS)

- ICS includes Dietetics, Exercise Physiology, Occupational Therapy, Podiatry, Physiotherapy, Social Work, and interdisciplinary complex self-management support. It serves as a bridge between hospital care and community services.
- Our team works in partnership with other services to improve health and functional outcomes, aiming to reduce hospital admissions for people with Diabetes, Chronic Cardiac and Respiratory Conditions, and other complex chronic illnesses
- At ICS, we focus on person-centred care

"Together, we connect with people living with chronic conditions to live the life they choose."

Background

- Northern Adelaide's Diabetes prevalence is **6.5%**, well above the national rate of 4.8% (ABS, 2021). It also has the highest proportion of vulnerable populations in SA (61%) (APHN, 2020).
- People in low socioeconomic areas face greater barriers to managing their health but benefit most from accessible, community-based support.
- Group-based self-management programs are proven to improve diabetes outcomes (Deakin et al., Cochrane, 2023).

Aim

- To address gaps in accessible, coordinated diabetes self-management support
- To support people facing socioeconomic barriers to access care
- To provide a holistic approach that integrates physical activity, education, peer support and tailored care
- To improve long-term health outcomes and reduce the burden on acute services

Who is involved

Program Participants: Adults with Type 1 and Type 2 Diabetes across NALHN
Multi-Disciplinary team: Exercise Physiologists, Dietitians, Chronic Disease Self-Management Practitioners (interdisciplinary AHPs), Podiatrist
Partners: Flinders University (clinical placement students and project evaluations), Consumers (co-designers and active contributors)

What does it look like?

8-week program:

- ✓ Weekly self-management workshops giving opportunities for social identification and peer modelling
- ✓ Bi-weekly supervised exercise sessions with BGL monitoring
- ✓ 1:1 Dietetics support and CONNECT interdisciplinary student clinic for community service linkage
- ✓ Consumer feedback and ongoing evaluation

Outcomes

Outcome measures for all clients captured pre- and post- program

Physical Outcomes

Stronger, more efficient muscle allows for improved glucose storage and uptake. Therefore, improvements in strength, can contribute to improve diabetes control			
Outcome Measure	**What are we measuring**	**Minimal Clinically Important Difference**	**LWWD participant outcomes**
Grip Strength	Indicator of overall body strength	2.69kg (non-dominant) and 2.44kg (dominant) (Bobos 2020)	↑3kg (L) and (R)
30s Bicep Curl Test	Upper limb functional strength	No MCID established in the literature	↑37.55 (L) ↑31.25% (R)
30s Sit to Stand Test	Lower limb functional strength	No MCID established in the literature for Diabetes population or healthy adults. COPD MCID is ≥2 reps and Hip OA is 2-3 reps	↑4 reps (44%)
6 Minute Walk Test	Functional capacity and aerobic fitness	No MCID established in literature for Diabetes population or healthy adults. COPD 25-35m Heart Failure 43m Peripheral Artery Disease 20-50m	↑98m

Patient Reported Self-Management Questionnaire

Diabetes Self-Management Questionnaire – Revised (DSMQ-R)	
Patient reported. Measures key self-management behaviours associated with blood sugar control. Focuses on actions that influence glycaemic control and overall diabetes outcomes	
Overall	↑9.5%
Diet	No change
Medication Management	↑28%
Glucose Monitoring	↑25%
Physical Activity	↑11%
Cooperation with Medical Team	↑5%
Adjusting Insulin	↑25%

"I am in control again thanks to their persistence, time and care"

Program Evaluation and Continuous Improvement Cycles

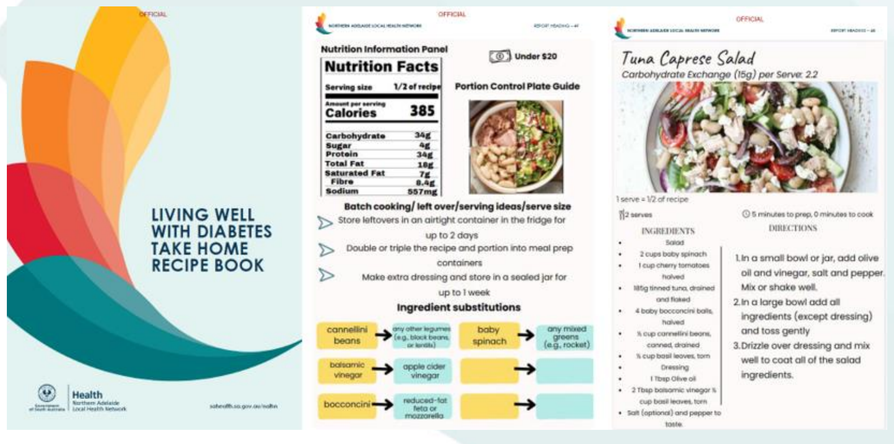
Four cohorts of Dietetics students participated in evaluating the LWWD program throughout its 2024/2025 setup and implementation.

Pre-implementation: Input from 34 stakeholders, including consumers and health professionals, confirmed the program met community needs. Recommendations included more nutrition education, smaller groups, diabetes educator involvement, and family engagement.

Pilot Evaluation: Participants reported improved diabetes knowledge, confidence, and daily management. Feedback led to session refinements such as deeper nutrition topics (e.g., glycaemic index, mindful eating) and splitting sessions for greater depth.

Six-Month Outcomes: Continued improvements in self-management were noted. Suggestions included adding pharmacists or diabetes nurse educators, peer support, better visual aids, tailored content for Type 1 and Type 2 diabetes, and enhanced tracking tools like HbA1c

Latest Developments: A consumer-informed recipe book was created to support dietary changes, reflecting participant preferences. Each evaluation cycle exemplifies consumer partnership, with participants actively shaping program planning, delivery, and evaluation.



Conclusions

- Living Well With Diabetes demonstrates a **sustainable, consumer-centred model** that improves physical health, self-management skills, and overall wellbeing.
- The program's collaborative design, robust evaluation, and strong consumer partnerships ensure it remains responsive to community needs.
- It offers a scalable, adaptable pathway to support people living with diabetes and can serve as a **blueprint for chronic condition management programs across health services.**

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