Hume Whittlesea Primary Care Partnership

Implementation Guide

Improving Coordination of Diabetes Care

Reviewed October 2014

Dianella Working Together

Northern Health

medicare local NORTHERN MELBOURNE Connecting health to meet local needs

Plenty Valley Community Health

Sunbury Community Health Centre All Year Round Quality Care

Acknowledgements

Hume Whittlesea Primary Care Partnership (HWPCP) would like to thank the following agencies for participating in the *HWPCP Improving Coordination of Diabetes Care Project:*

- Dianella Community Health (DCH)
- Northern Health Ambulatory Services (NH)
- Northern Melbourne Medicare Local (NMML)
- Plenty Valley Community Health (PVCH)
- Sunbury Community Health (SCH)

We would also like to acknowledge:

- Marie Gill, from Gill and Willcox gill+willcox, who provided consultation throughout this project
- Local General Practice staff, who participated in consultations and piloting of the HWPCP Adult Diabetes Service Pathway, and
- Royal District Nursing Service for their ongoing interest in the project.

This guide has been adapted from the Eastern Metropolitan Region Improving the Diabetes Journey - Type 2 Diabetes System Improvement project, Inner and Outer East Primary Care Partnerships.
www.iepcp.org.au/sites/www.iepcp.org.au/files/ItDJ%20Implementation%20Guide%20Updated%2015%206%20%202012.pdf

Contents

Abbreviations

ADTT	Adult Diabetes Triage Tool
ADSP	Adult Diabetes Service Pathway
DCH	Dianella Community Health
GP	General Practice
HWPCP	Hume Whittlesea Primary Care Partnership
INI	Initial Needs Identification
NH	Northern Health
NMML	Northern Melbourne Medicare Local
PVCH	Plenty Valley Community Health
SCH	Sunbury Community Health
VSRF	Victorian State-wide Referral Form

1.0 Overview

Northern Health and Community Health in the HWPCP have agreed to a number of system changes to improve integration, and coordination of diabetes care in the catchment. These changes include:

1. Use of common Tools across the catchment to assess diabetes risk and prioritise care
    - The Tools will define entry point into appropriate diabetes services and form the basis for determining appropriate care pathways.

2. GP Referral Documentation
    - An agreed preferred standard of referral documentation.

3. Agreement across the catchment on minimum services a client should receive.
    - An agreed "Client Charter" based on best practice of care.

4. Care coordination
    - Defined roles around provision of care, identification of who provides what levels of care based on agency resources, processes for handover of clients during step down or escalation of care, and consistency of inter-agency care plans for handover of clients across the PCP catchment.

2.0 Common Tool to Assess Diabetes Risk and Prioritise Care

The Hume Whittlesea Primary Care Partnership Adult Diabetes Triage Tool (HWPCP ADTT) has been developed to support categorisation (and prioritisation) of clients on the basis of their risk of disease progression and/or complications, and identify the level of care required. Refer to Appendix 1 for a copy of the HWPCP ADTT.

The HWPCP ADTT is a triage tool to be used at point of intake. Intake staff are to utilise the HWPCP ADTT during the Initial Needs Identification (INI) process to support categorisation (and prioritisation) of clients on the basis of their disease progression and/or complications, and define the level of care required. Clients will be categorised as requiring either a Standard, Intermediate or Extended Pathway. This process will enable Intake staff to identify and direct clients to the most appropriate services within their agency, or to identify the need for referral to another more appropriate agency in the catchment.

The HWPCP ADTT has been kept as simple as possible for ease of implementation at point of intake across the service system. In keeping this tool simple, it is acknowledged that the HWPCP ADTT does by no means provide a comprehensive clinical assessment, but is a screening tool only to facilitate initial prioritisation and pathway of care selection. It should be noted that a clinical assessment might alter the initial pathway (Standard, Intermediate or Extended) allocated to a client. Education on use of the HWPCP ADTT and applying referral information may be required for Intake staff. Clinical input is also available for Intake Staff as required.

2.1 Process for embedding the HWPCP ADTT into the care delivery system

1. General Practice Referrals

- The HWPCP ADTT will be used by Intake staff during Initial Needs Identification (INI) process to determine the appropriate care pathway for a client.
- If the HWPCP ADTT determines that a client requires a care pathway not provided by the agency, the client is informed and if consented, the referral is forwarded to the appropriate agency.
- Intake staff are required to inform the GP that the client has been identified as requiring a service at another agency (ie. letter).

2. Self referrals

- If a client self refers (self referrals are not accepted by NH), the HWPCP ADTT will be used by Intake staff during Initial Needs Identification (INI) process to determine the appropriate care pathway for a client.
- If inadequate information is available from the client, Intake staff should contact the GP for additional information required once client consent has been gained.
- If the HWPCP ADTT determines that a client requires a care pathway not provided by the agency, the client is informed and if consented, the referral is forwarded to the appropriate agency.

2.2 Inter-agency Redirection of Referrals

The HWPCP ADTT facilitates agencies to identify when a referral to a more appropriate agency is required. To support this process, partner agencies have endorsed inter-agency redirection of referrals when client consent has been gained. This process will support more timely service for a client as agencies will no longer need to forward the referral back to the GP requesting they redirect.

Inter-agency Redirection Process for Intake Staff

1. Intake staff to inform and gain consent from client before redirecting referral
2. Intake staff to send a letter to GP informing them that the client has been identified as requiring a service at another agency
3. The agency that *receives the redirected referral* for provision of care is responsible for collecting any incomplete information from the GP (ie. medical history, pathology, medication etc)

NH exception: where client consent is difficult to gain in a timely manner, the referral will be sent back to the GP requesting they redirect the referral.

3.0 Standard GP Referral Documentation

A HWPCP Adult Diabetes Service Pathway (HWPCP ADSP) has been developed to assist GP's and practice nurses to identify the service that best matches the needs of a client with diabetes. Refer to Appendix 2 for a copy of the HWPCP ADSP. The HWPCP ADSP aims to minimise the need for inter-agency redirection of referrals by ensuring GP's can identify and refer to the most appropriate service in the first instance.

Partner agencies have also agreed on a minimum standard of GP referral documentation. This will:

- support Intake staff utilising the HWPCP ADTT to have adequate information to complete the categorisation (and prioritisation) of clients and identify the level of care required, and
- promote consistent GP communication and agency expectation across the catchment.

Refer to Appendix 3 for a HWPCP GP Diabetes Referral Form (DRF) outlining the agreed minimum standard information required from GPs utilising services across the HWPCP catchment. The HWPCP GP Diabetes Referral Form is required to be completed with supporting documentation.

Agencies may choose to modify this template with their agency logo and outline any additional information they may require for their own internal prioritisation processes.

Please note: Victorian State-wide Referral Form (VSRF) will be superseded by the SCTT GP Referral Tool – implementation date TBC.

4.0 HWPCP Diabetes Care Pathways

Partner agencies have agreed on minimum services a client should receive based on best practice. The "HWPCP Diabetes Care Pathways" outline the services that all clients with diabetes should have the opportunity *to access*, at different life or disease stages based on the level of complexity of their condition. Refer to Appendix 4 for the Diabetes Care Pathways and Care Components.

The HWPCP Diabetes Care Pathways are selected for a client at the point of intake utilising the HWPCP ADTT. Three care pathways have been identified which are; Standard, Intermediate and Extended. Categorisation is based on risk of disease progression and/or complications.

The Standard Care Pathway outlines the minimum education and services (refer Appendix 4) that all people with diabetes should receive, 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. The care components specified are the *minimum requirements for each level of care*, therefore, individual agencies may decide to add additional elements of care to each of the care pathways specific to their agency.

If agencies are not able to provide all components of the pathway, they should make appropriate arrangements through referral to other services and/or liaison with the client's general practitioner to ensure the client receives all the identified components of care. A HWPCP Diabetes Care Service Matrix has been developed for GPs and agencies to visually identify project partner's availability of care components. Refer Appendix 5 for the HWPCP Diabetes Care Service Matrix.

A brief summary of each individual care component is provided in Appendix 6. It is not intended to be a complete scope of professional practice. Individual disciplines will have access to this through their Professional Associations.

Appendix 1: Hume Whittlesea Primary Care Partnership Adult Diabetes Triage Tool (HWPCP ADTT)

Hume and Whittlesea Primary Care Partnership - Adult Diabetes Triage Tool (March 2014)

Stream	Eligibility (One or more ticks)	Where available	Provider details
Urgent Pathway Brief intervention Stabilisation and transfer • Immediate first appointment to Endo within 1 week. • DNE appointment to be made within 2 weeks to either NH or PVCH depending on the patient's location	☐ **Recent Diabetic Ketoacidosis (DKA)** - *must be followed up by RN CDE /DE or DNP within 48 hours of discharge and Endo outpatient appointment made as per discharge summary/referral.* ☐ **Hyperosmolar Hyperglycemic State (HHS)** - *must be followed up by RN CDE /DE or DNP within 48 hours of discharge and Endo outpatient appointment made as per discharge summary/referral.* ☐ **Type 1 and LADA for insulin commencement stabilisation** - *must be followed up by RN CDE/DE or DNP within 48 hours of discharge and Endo outpatient appointment made as per discharge summary/referral* ☐ **Recurrent hypoglycemia (unexplained BGL <4 mmol >2 per week)** - *for outpatient appointment with a RN CDE/DE within a week from receipt of referral.* ☐ **Active foot ulcer or wound** - *for outpatient appointment within 1 week from receipt of referral*	**Northern Health** ☐ Priority appointment at NH ☐ Endocrinology Clinic (MBS) *DNE and DIET appointment can be made to either NH or PVCH depending on the patient's location. Endo appointment will remain at NH.	**Northern Health (Central Intake)** T: 9495 3443 F: 9467 8698 www.nh.org.au
Intermediate Care Pathway (Type 1, LADA & Type 2 Diabetes) • First appointment with the DNE within 4-8 weeks. • DNE will escalate to either ENDO or diabetes nurse practitioner after initial ax	☐ HbA1c >8.5% (>69mmol/mol) with or without a hospital presentation/admission in the past 12 months ☐ BGL >20mmol/L ☐ Triglycerides >11.2mmol/L ☐ eGFR <45 (mL/min/ 1.73m^2) ☐ T2DM requiring insulin or GLP-1 initiation or titration ☐ Active foot pathology with a history of complications ☐ Newly diagnosed T2DM not stablised within 3 months ☐ On corticosteroids (prednisolone and dexamethasone) regardless of HbA1c	**Health Independence Program (HIP)** ☐ BECC ☐ BHS ☐ CHS (re-open in 2014) ☐ PVCH **Sunbury Community Health Service** *Appointment can be made to NH, PVCH or SCH depending on the patient's location. If unsure between NH and PVCH, refer to Northern Health who will triage to PVCH if required.	**Northern Health (Central Intake)** T: 9495 3443 F: 9467 8698 www.nh.org.au **Plenty Valley Community Health** T: 9409 8724 F: 9408 9508 www.pvch.org.au **Sunbury Community Health Service** T: 9744 4455 F: 9744 6777 www.sunburychc.org.au
Standard Care Pathway (Type 2 Diabetes – community health)	☐ Pre-diabetes ☐ Newly diagnosed type 2 irrespective of HbA1c or BGLs ☐ HbA1c ≤8.5% (≤69mmol/mol) ☐ eGFR >45(mL/min/ 1.73m^2) ☐ No active foot pathology and no history of complications ☐ Not requiring insulin initiation or titration	☐ Dianella CHS ☐ Sunbury CHS ☐ PVCH (general care team) ☐ Medicare funded private allied health services	**Dianella Community Health Service** T: 1300 786 450 F: 1300 786 480 www.dianella.org.au **Plenty Valley Community Health Service** T: 9409 8724 F: 9408 9508 www.pvch.org.au **Sunbury Community Health Service** T: 9744 4455 F: 9744 6777 www.sunburychc.org.au

Appendix 2: Hume Whittlesea Primary Care Partnership GP Adult Diabetes Service Pathway (HWPCP ADSP)

Improving Coordination of Diabetes Care in Hume and Whittlesea

March 2014

Improved referral process

The Hume and Whittlesea catchment has one of the highest admission rates for avoidable diabetes complications. Responding to this, GPs and health agencies in the Hume and Whittlesea Primary Care Partnership (HWPCP) are working together to improve communication between service providers and to integrate diabetes care across the catchment.

The aim is to improve the way referrals are handled to ensure that people with diabetes are referred to the service that is able to provide the level of care that best meets their needs. To enable this, agencies are requesting a *minimum data set of information from GPs* when people with diabetes are referred.

A HWPCP Adult Diabetes Triage Tool will be applied within agencies using this referral information to:

- ensure consistency when triaging and determining complexity, and
- help agencies manage referrals more efficiently and to redirect when necessary to partner agencies (with notification and feedback to you). *NOTE: Redirection can only occur between the partner agencies listed (on the reverse side). GPs will need to refer directly to other agencies.*

A HWPCP Adult Diabetes Service Pathway (on the reverse side) has been developed to help GP's and nurses identify the service that best matches the needs of a patient with diabetes. HWPCP agencies have agreed on minimum services a patient should receive informed by evidence based practice. The "HWPCP Diabetes Care Pathways" outlines the services that all patients with diabetes should receive, at different life or disease stages based on the level of complexity of their condition. The *minimum* components for each level of care are outlined in Table 1.

Table 1: HWPCP Diabetes Care Pathways

	Standard Pathway of Care	Intermediate Pathway of Care	Urgent Pathway of Care
Wait time for comprehensive assessment *Wait times are subject to demand. Please contact the provider directly for accurate wait times. Contact details are provided on the reverse side.*	14-70 days *(2-10 weeks)*	10-56 days *(2- 8 weeks)*	1-14 days *(1-2 weeks)*
Components of Care *A tick ✓ indicates this component of care is provided*			
General Practice – Annual Cycle of Care	✓	✓	✓
Individual assessment: including complications screening, management and prevention	✓	✓	✓
Intra-agency Care Plan	✓	✓	✓
Diabetes education	✓	✓	✓
Dietitian assessment	✓	✓	✓
Podiatry assessment	✓	✓	✓
Ongoing self-management support	✓	✓	✓
Support group and/or counseling	✓	✓	✓
Urgent GP medical review/Endocrinology referral		✓	✓
Short term (intensive) care coordination		✓	✓
Inter-agency care plan		✓	✓
Review	6 – 12 monthly	Monthly for 6/12, then 3-6/12ly minimum	Weekly until stable, then 1/12ly until discharge

Hume Whittlesea PCP Adult Diabetes Service Pathway

Stream	Eligibility (One or more ticks)	Where available	Provider details
Urgent Pathway Brief intervention Stabilisation and transfer • Immediate first appointment to Endo within 1 week. • DNE appointment to be made within 2 weeks to either NH or PVCH depending on the patient's location	☐ **Recent Diabetic Ketoacidosis (DKA)** - *must be followed up by RN CDE /DE or DNP within 48 hours of discharge and Endo outpatient appointment made as per discharge summary/referral.* ☐ **Hyperosmolar Hyperglycemic State (HHS)** - *must be followed up by RN CDE /DE or DNP within 48 hours of discharge and Endo outpatient appointment made as per discharge summary/referral.* ☐ **Type 1 and LADA for insulin commencement stabilisation** - *must be followed up by RN CDE/DE or DNP within 48 hours of discharge and Endo outpatient appointment made as per discharge summary/referral* ☐ **Recurrent hypoglycemia (unexplained BGL <4 mmol >2 per week)** - *for outpatient appointment with a RN CDE/DE within a week from receipt of referral.* ☐ **Active foot ulcer or wound** - *for outpatient appointment within 1 week from receipt of referral*	**Northern Health** ☐ Priority appointment at NH ☐ Endocrinology Clinic (MBS) *DNE and DIET appointment can be made to either NH or PVCH depending on the patient's location. Endo appointment will remain at NH.	**Northern Health (Central Intake)** T: 9495 3443 F: 9467 8698 www.nh.org.au
Intermediate Care Pathway (Type 1, LADA & Type 2 Diabetes) • First appointment with the DNE within 4-8 weeks. • DNE will escalate to either ENDO or diabetes nurse practitioner after initial ax	☐ HbA1c >8.5% (>69mmol/mol) with or without a hospital presentation/admission in the past 12 months ☐ BGL >20mmol/L ☐ Triglycerides >11.2mmol/L ☐ eGFR <45 (mL/min/ 1.73m^2) ☐ T2DM requiring insulin or GLP-1 initiation or titration ☐ Active foot pathology with a history of complications ☐ Newly diagnosed T2DM not stablised within 3 months ☐ On corticosteroids (prednisolone and dexamethasone) regardless of HbA1c	**Northern Health** **Plenty Valley Community Health** **Sunbury Community Health Service** *Appointment can be made to NH, PVCH or SCH depending on the patient's location. If unsure between NH and PVCH, refer to Northern Health who will triage to PVCH if required.	**Northern Health (Central Intake)** T: 9495 3443 F: 9467 8698 www.nh.org.au **Plenty Valley Community Health** T: 9409 8724 F: 9408 9508 www.pvch.org.au **Sunbury Community Health Service** T: 9744 4455 F: 9744 6777 www.sunburychc.org.au
Standard Care Pathway (Type 2 Diabetes – community health)	☐ Pre-diabetes ☐ Newly diagnosed type 2 irrespective of HbA1c or BGLs ☐ HbA1c ≤8.5% (≤69mmol/mol) ☐ eGFR >45(mL/min/ 1.73m^2) ☐ No active foot pathology and no history of complications ☐ Not requiring insulin initiation or titration	☐ Dianella CHS ☐ Sunbury CHS ☐ PVCH (general care team) ☐ Medicare funded private allied health services	**Dianella Community Health Service** T: 1300 786 450 F: 1300 786 480 www.dianella.org.au **Plenty Valley Community Health Service** T: 9409 8724 F: 9408 9508 www.pvch.org.au **Sunbury Community Health Service** T: 9744 4455 F: 9744 6777 www.sunburychc.org.au

Appendix 3: Hume Whittlesea Primary Care Partnership GP Diabetes Referral Form (HWPCP GP DRF)

HUME WHITTLESEA CATCHMENT DIABETES REFERRAL FORM

Date of referral:

Referral to: (Please tick)

Northern Health	Fax: 9467 8698	Phone: 9495 3443	
Dianella Community Health Service	Fax: 1300 786 480	Phone 1300 786 450	
Plenty Valley Community Health	Fax: 9408 9508	Phone: 9409 8724	
Sunbury Community Health Centre	Fax: 9744 6777	Phone: 9744 4455	

To manage referrals more efficiently, your referral may be redirected when necessary to one of the above partner agencies. (This will occur with notification and feedback to you).

Part A: PATIENT DETAILS

Name of patient:	Referring GP:
DOB:	Name of Practice:
Address:	Practice Phone:
Phone (H) Phone (m)	Practice Fax:
Interpreter required: Yes ☐ No ☐	If interpreter required: Language spoken

In order to triage and process the referral appropriately and for comprehensive assessment and management of the patient/client, we require the following information to be forwarded:

Reason for Referral: **Diabetes History:**

1

Other History:
Is the patient seeing an Endocrinologist Yes ☐ No ☐ If yes, Contact details of Endocrinologist.
Current Medications:
Investigation Results: - Please include the following (<3 months old): HbA1c (within last 3 months), U&Es including eGFR, Fasting Glucose/OGTT, Fasting Lipid Profile (TC, Trig, HDL, LDL, Ratio), LFTs, FBE and Urine - Micro albumin/ACR:

Reason for Referral- essential information

Diabetes related problems (Reason for referral)	
Acutely elevated blood glucose > 20 mmol/L	Yes ☐ No ☐
Recurrent hypoglycaemia	Yes ☐ No ☐
Active foot ulcer or wound	Yes ☐ No ☐
Recent Diabetic Ketoacidosis (DKA)	Yes ☐ No ☐
Recent Hyperosmolar Hyperglycaemic State (HHS)	Yes ☐ No ☐
LADA for insulin commencement	Yes ☐ No ☐
Triglycerides >11.2mmol/L	Yes ☐ No ☐
Commence insulin	Yes ☐ No ☐

2

T2DM requiring insulin or GLP-1 initiation or titration	Yes ☐ No ☐
eGFR <45 (mL/min/ 1.73m2)	Yes ☐ No ☐
On corticosteroids (prednisolone and dexamethasone) regardless of HbA1c	Yes ☐ No ☐
Requiring insulin titration	Yes ☐ No ☐
Pre diabetes	Yes ☐ No ☐
New diagnosis	Yes ☐ No ☐

Diabetes- related hospital admission within the last 12 months: Yes ☐ No ☐

Details for after hours emergency contact for patient:
Name:
Phone No.

The client has consented to this information being sent to

Signed: _____ (Client)

Or: (Provider) _____ on behalf of client (verbal consent)

*******Please ensure the below checklist is covered in your investigation results*******

DIABETES REFERRAL CHECKLIST - Your referral will be sent back for completion if checklist is not covered

HbA1C (within last 3 months)	☐	U&E including eGFR	☐
Fasting Glucose/OGTT	☐	LFTs	☐
Fasting Lipid Profile: TC, Trig, HDL, LDL, Ratio	☐	FBE	☐
Urine- Micro albumin/ACR	☐		

3

PART B : INJECTABLE (INSULIN/GLP-1) INITIATION/STABILISATION REQUEST

Note - Form must be signed by requesting GP for Diabetes Educators to proceed with insulin or GLP-1 initiation or stabilisation.

Could you please commence:

Insulin/GLP-1 initiation/stabilisation Request (order and regimen):

Medication	Before Breakfast Dose (Units)	Before Lunch Dose (Units)	Before Dinner Dose (Units)	Before Bed Dose (Units)
Signature:	_____	_____	_____	_____

Dose adjustment (please select yes or no): Yes ☐ No ☐

Undertaken by GP:

Enrolled patient on self-titration program:

Changes to other glucose lowering medications - please specify:

Target/reportable levels

Fasting:
Pre prandial:
Post prandial:

Dr Name: _____

Dr Signature: _____

4

Appendix 4: Hume Whittlesea Primary Care Partnership Diabetes Care Pathways & Components of Care

	Standard Pathway of Care	Intermediate Pathway of Care	Urgent Pathway of Care
Wait time for comprehensive assessment *Wait times are subject to demand. Contact the provider directly for accurate wait times.*	**14-70 days** ***(2-10 weeks)***	**10-56 days** ***(2- 8 weeks)***	**1-14 days** ***(1-2 weeks)***
Components of Care (tick ✔ indicates this component of care is provided)			
General Practice – Annual Cycle of Care	✔	✔	✔
Individual assessment: including complications screening, management and prevention (see guide for contents)	✔	✔	✔
Intra-agency Care Plan	✔	✔	✔
Diabetes education	✔	✔	✔
Dietitian assessment	✔	✔	✔
Podiatry assessment	✔	✔	✔
Ongoing self-management support	✔	✔	✔
Support group and/or counselling	✔	✔	✔
Urgent GP medical review/Endocrinology referral		✔	✔
Short term (intensive) care coordination		✔	✔
Inter-agency care plan		✔	✔
Review	**6 – 12 monthly**	**Monthly for 6/12, then 3-6/12ly minimum**	**Weekly until stable, then 1/12ly until discharge**

Appendix 5: Hume Whittlesea Primary Care Partnership Diabetes Care Service Matrix

Diabetes Care Service Matrix

Improving Coordination of Diabetes Care in Hume & Whittlesea: Care Pathway Components

Components of Care	Northern Health	Dianella Community Health	Plenty Valley Community Health	Sunbury Community Health	Royal District Nursing Service
General Practice – Annual Cycle of Care		✓	✓	✓	
Individual assessment: including complications screening, management and prevention	✓	✓	✓	✓	✓
Intra-agency Care Plan		✓	✓	✓	✓
Diabetes education	✓ Credentialled Diabetes Educator (CDE) or Diabetes Educator (DE)	✓ Credentialled Diabetes Educator (CDE) or Diabetes Educator (DE)	✓ Credentialled Diabetes Educator (CDE) or Diabetes Educator (DE)	✓ Registered Nurse Credentialled Diabetes Educator (RN CDE)	✓ Registered Nurse (RN)
Dietitian assessment	✓	✓	✓	✓	
Podiatry assessment	✓	✓	✓	✓	
Ongoing self-management support		✓	✓	✓	
Support group and/or counselling		✓	✓	✓	
Diabetes Education Group		✓	✓	✓	
Urgent GP medical review/Endocrinology referral	✓	✓	✓	✓	
Short term (intensive) care coordination	✓	✓	✓	✓	
Inter-agency care plan	✓	✓	✓	✓	
Review	✓	✓	✓	✓	
Requires home visit (if eligible)	✓	✓		✓	HACC eligible clients only.
Service Provider Contact details	**Northern Health** T: 1300 128 539 F: 9467 8698 www.nh.org.au	**Dianella Community Health Service** T: 1300 786 450 F: 1300 786 480 www.dianella.org.au	**Plenty Valley Community Health** T: 9409 8724 F: 9408 9508 www.pvch.org.au	**Sunbury Community Health Service** T: 9744 4455 F: 9744 6777 www.sunburychc.org.au	**Royal District Nursing Service** T: 1300 33 44 55 www.rdns.com.au

Appendix 6: HWPCP Diabetes Care Pathways

Summary of Individual Components of Care

This section of the guide provides a brief explanation of the individual care components under each care pathway. It is not intended to be a complete scope of professional practice. Individual disciplines will have access to this through their professional associations.

The HWPCP Diabetes Care Pathways for Type 1 & 2 clients has been informed by the current available evidence base and through consultation with clinicians in the HWPCP catchment.[1-11] The Standard Pathway of Care provides information that all clients with Type 1 & 2 Diabetes should receive. The Intermediate and Extended Care Pathway indicates the additional services that clients categorised into these categories should receive *on top of* the Standard Care Pathway services.

1. General Practice - Annual Cycle of Care

The general practitioner is a key contact for people with diabetes. The Annual Cycle of Care outlines the minimum requirements for monitoring of diabetes control and complications which complement the education and service delivery components outlined in the HWPCP Diabetes Care Pathways.

It is expected that agencies would liaise with each client's general practitioner to ensure clients receive all components of care outlined in their designated pathway and the annual cycle of care to avoid duplication of services. In addition, health care partners have a responsibility to assist the client in obtaining access to general practice and to inform clients regarding the expected minimum standards outlined in the Annual Cycle of Care.

Table 1: Minimum requirements of care for a GP to complete an Annual Cycle of Care (Type 1 & 2 Diabetes)

Activity	Frequency/Description
Assess diabetes control by measuring HbA1c	At least once every year
Ensure that a comprehensive eye examination is carried out	At least once every two years
Measure weight and height and calculate Body Mass Index (BMI)	At least twice every cycle. Initial visit: measure height and weight and calculate BMI
Measure blood pressure	At least twice every cycle of care
Examine feet	At least twice every year
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Provide self care education	Client education regarding diabetes management
Review dietary patterns	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate levels of physical activity
Check smoking status	Encourage smoking cessation (if relevant)
Review of medication	Medication review

For any changes to the Annual Cycles of Care visit:
www9.health.gov.au//mbs/search.cfm?q=annual+cycle+of+care+diabetes+&sopt=S[12]

2. Individual assessment

An individual assessment should include assessment for depression and complications screening and information on prevention and management.[14] Ideally individual assessment will be provided by a Credentialled Diabetes Educator (CDE) who has completed an ADEA accredited course.[7] Refer to "Diabetes Education" outlined below for agreed standards of diabetes education content.

3. Complications screening

Where practitioners do not have the skills or resources to undertake appropriate screening activities they should liaise with the client's general practitioner and/or endocrinologist to ensure that the appropriate referrals are made to ensure screening guidelines are met.

4. Intra-agency Care Plan

An intra-agency care plan is usually developed to:

- coordinate internal service provision
- facilitate communication of agreed strategies and service
- communicate interventions between the practitioners
- articulate shared goals and outcomes
- outline the roles and responsibilities of each practitioner, and identify the practitioner responsible for care coordination and/or case management.

5. Diabetes Education

Diabetes education is a core component of diabetes care for people newly diagnosed, in the early stages, and living with type 1 and 2 diabetes long-term. It is an expectation that services in the HWPCP will provide the below agreed standards for diabetes education.[5-8,13,14]

Provider

Ideally diabetes education will be provided by a Credentialled Diabetes Educator who has completed an ADEA accredited course, complimented by a multidisciplinary team approach (including podiatry and dietetics) when available.[6]

Diabetes Education Content

1. Chronic disease risk factors / lifestyle modification through group or individual consultation:
    - physical activity
    - smoking cessation
    - alcohol and drugs
2. General nutrition education/weight management for diabetes
   General nutrition therapy is best provided by Dietitians, but it is suitable for CDE's to provide this information if necessary. Any resources used to complement this education should be developed with/by an Accredited Practising Dietitian.[15]
    - General/introductory nutrition information on the role of food in diabetes management
    - Basic food composition (ie. identification of protein, fat and carbohydrate sources)
    - General aims of dietary intervention (ie weight management, blood glucose, lipid and blood pressure control
    - Prevention and treatment of hypoglycaemia
    - Introduction to basic principles of carbohydrate counting where appropriate
    - Consideration of carbohydrate intake with respect to usual physical activity
    - Appropriate food choices for illness of short duration
    - General tips for cooking, shopping, eating out and recipe modification to promote healthy food choices

- General recommendations regarding food requirements for travel, during fasting, shift work, religious or other special occasions
- General recommendations regarding alcohol consumption[15]

3. Diabetes self management
    - Self monitoring eg. Blood glucose monitoring, hypoglycaemia management
    - Implications for employment
    - Sick day management
    - Medications and/or insulin
    - Pregnancy and pre-planning pregnancy where appropriate
    - Travel
4. Complications monitoring & education
    - Foot care
    - Vision / eyes
    - Kidney disease
    - Heart disease
    - Oral / dental including recommendation for assessment by a dentist[16]
    - Sexual health
    - Pathology testing required and frequency
5. Driving and VicRoads assessment – Ensure client is aware of obligations and facilitate completion of assessment. For more information refer: www.vicroads.vic.gov.au/Home/Licences/MedicalConditions/Diabetes.htm
6. NDSS registration and information
7. Psychosocial impacts and management, including stress management and depression and anxiety
8. Immunisation

Key features of diabetes education

- Involvement of family, carers where appropriate
- Interpreter access where appropriate
- Self management focus (see self management information)
- Multidisciplinary approach
- Establish and maintain a system of recall and review based on appropriate guidelines
- Delivered in individual or group context
- Mode of delivery must take into account client cultural and linguistic background, literacy, age, suitability for group
- Communication with people with diabetes is consistent with the Diabetes Australia Position Statement: A new language for diabetes- Improving communications with and about people with diabetes at: www.diabetesaustralia.com.au/en/Media-Centre/Media-Releases/Diabetes-AustraliaLanguage-Position-Statement/

6. Podiatry Assessment

All people with diabetes must have the opportunity to access a podiatrist. An assessment by a podiatrist should be conducted and include an annual neurovascular assessment, identification of risk factors, and advice on daily care routine to reduce the risk of injuries and complications to ensure adequate foot health.[17]

7. Dietetic Assessment

Nutrition management includes both general nutrition education and medical nutrition therapy (MNT). General nutrition education covers a range of nutrition topics and can be given as introductory information at diagnosis or part of ongoing education. MNT should only be provided by Accredited Practising Dietitians. MNT is an individualised and comprehensive clinical intervention which builds on general nutrition education to achieve improved clinical and health outcomes. MNT includes nutrition assessment, nutrition prescription, knowledge and skills development and behavioural counselling. MNT is client focussed, based on an assessment of blood glucose,

blood pressure and lipid levels, status of diabetes and life stage, diabetes knowledge base, self motivation and readiness to change. It also includes adapting advice for other medical conditions and includes integration of the social, cultural and environmental factors which affect food intake. [15]

All people with diabetes must have the opportunity to access an Accredited Practising Dietitian for individualised diabetes eating plan, that takes into account lifestyle factors and individual health needs. Dietitians will educate on reading food labels, modifying recipes and supporting appropriate food choices. Intensive insulin adjustment and carbohydrate counting programs (such as DAFNE) should be available for clients with type 1 diabetes. Dietitians will also assess for disordered eating practices.[9,18]

8. Ongoing Self Management Support

Self management support differs from education in that it focuses on helping clients develop the self care skills to manage not just the diabetes but the role and emotion changes that often accompany having a chronic condition.

Ongoing self-management support may be incorporated into other components of the pathways of care (such as the care coordination or diabetes education roles) or be provided in as a separate service (such as health coaching) or a specific self management group program.[2,19]

Self-management support should include the following:

- Client-centred partnership approach to determine management plan, share responsibility and establish shared goals and action plans.
- Focus on increasing self-efficacy
- Support clients to develop goal setting and action planning skills to support behaviour change
- Provide appropriate tools for clients to make informed decisions
- Strategies and skills to assist clients and families to live with challenges of chronic conditions such as communication and symptom management skills.

For more information on self-management refer:
www.health.vic.gov.au/pcps/downloads/selfmanagementguide.pdf

9. Support Group and/or Counselling

All people with diabetes may benefit from the opportunity to access support groups and/or counselling, this should be offered to all people with type 1 and 2 diabetes. Intensified education and psychological support programs should be considered when treatment goals are not being met.[9,14,19] For more information on local diabetes support groups for clients, contact Diabetes Australia on 1300 136 588. The following websites provide online assistance and support:

- Type 1 and 2 Diabetes Counselling online: www.diabetescounselling.com.au
- Type 1 Diabetes Network: www.realitycheck.org.au

10. Urgent Medical Review

Any person with type 2 diabetes categorised as appropriate for an Extended Pathway should have a general practitioner review and access to an endocrinology medical review if clinically indicated to support appropriate planning of care with a multidisciplinary team.[19,6]

Clients with type 1 diabetes should have an endocrinology medical review to support appropriate planning of care with a multidisciplinary team. A shared care approach by general practitioner and specialist will provide the best combination of specialised expertise and continuity of care. The specialist should function as part of a multi-disciplinary diabetes care team which can provide a comprehensive diabetes education program.[9]

11.Short Term Care Coordination

Clients categorised as appropriate for the Intermediate or Extended Care Pathway are likely to require multiple services from multiple service providers, and present with an additional number of complexities in addition to their diabetes diagnosis. Care coordination across agencies is especially important for these clients.[13,11]

12. Inter-agency Care Plan

Interagency care planning is a core support for people with complex and multiple needs who require the services of more than one agency.[11]

References

1. National Health Priority Action Council. (2006). *National service improvement framework for diabetes.* Australian Government Department of Health and Ageing, Canberra.

2. Australian Diabetes Educators Association. (2008). Positions Statement: Client Centred Care. *Australian Diabetes Educator,* Volume 11 Number 1, March 2008, page 26-28. Retrieved 16 November 2012 from website: www.adea.com.au/asset/view_document/979315962

3. Diabetes Australia and the Royal Australasian College of General Practitioners. (2012). *Diabetes Management in General Practice Guidelines for Type 2 Diabetes 12-13.* Diabetes Australia, Canberra. Retrieved 16 November 2012 from website: www.diabetesaustralia.com.au/Documents/DA/What's%20New/12.10.02%20Diabetes%20Management%20in%20General%20Practice.pdf

4. Eigenmann C, Colagiuri R. (2007). *Outcomes and Indicators for Diabetes Education - A National Consensus Position*. Diabetes Australia, Canberra.

5. Australian Diabetes Educators Association. (2003). *National Standards of Practice for Diabetes Educators* 2003. Australian Diabetes Educators Association, ACT. Retrieved 16 November 2012 from website: www.adea.com.au/asset/view_document/979315968

6. Australian Diabetes Educators Association. *National Standards for Diabetes Education Programs. Australian Diabetes Educators Association, ACT*. Available to order from at: www.adea.com.au/main/aboutus/ourproductsandpublications/orderpublications

7. Australian Diabetes Educators Association. (2007). *The Credentialled Diabetes Educator in Australia – Role and Scope of Practice* 2007. Australian Diabetes Educators Association, ACT. Retrieved 16 November 2012 from website: www.adea.com.au/asset/view_document/979315969

8. Australian Diabetes Educators Association. (2008). *National Core Competencies for Credentialled Diabetes Educators* 2008. Australian Diabetes Educators Association, ACT. Retrieved 16 November 2012 from website: www.adea.com.au/asset/view_document/979315967

9. Diabetes Craig ME, Twigg SM, Donaghue KC, Cheung NW, Cameron FJ, Conn J, Jenkins AJ, Silink M, for the Australian Type 1 Diabetes Guidelines Expert Advisory Group. (2011). *National evidence-based clinical care guidelines for type 1 diabetes in children, adolescents and adults.* Australian Government Department of Health and Ageing, Canberra. Retrieved 16 November 2012 from website: www.diabetessociety.com.au/downloads/Type1guidelines14Nov2011.pdf

10. American Diabetes Association. (2012). Standards of Medical Care in Diabetes – 2012. *Diabetes Care Journal, January 2012,* Vol 35 no. Supplement 1 S11-S63. Retrieved 16 November 2012 from website: www.care.diabetesjournals.org/content/35/Supplement_1/S11.full

11. Primary Care Partnerships. (2009). *Good practice guide for practitioners: a resource of the Victorian Service Coordination Practice Manual.* Department of Human Services, Victoria.

12. MBS Online. (2012). *Completion of the Annual Diabetes Cycle of Care for Client with Established Diabetes Mellitus - (Items 2517 - 2526 and 2620 - 2635).* Australian Government: Department of Health and Aging. Retrieved, 16 November, 2012, from website: www9.health.gov.au//mbs/search.cfm?q=annual+cycle+of+care+diabetes+&sopt=S

13. Department of Human Services. (2008). Revised *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services.* Victorian Government Department of Human Services, Melbourne.

14. National Health Priority Action Council. (2006). National *service improvement framework for diabetes.* Australian Government Department of Health and Ageing, Canberra.

15. Dietitians Association of Australia. (2012) *The Role of Credentialled Diabetes Educators and Accredited Practising Dietitians in the Delivery of Diabetes Self Management and Nutrition Services for People with Diabetes.* Retrieved 18 July 2013 http://daa.asn.au/wp-content/uploads/2012/05/CDEAPD_FINAL.pdf

16. Diabetes Australia (2012). *Oral Health and Diabetes.* Retrieved 16 November 2012 from website: www.diabetesaustralia.com.au/en/NDSS-Content/Diabetes-Information-Sheets/Oral-Health-and-Diabetes/

17. APodA Victoria. 2002. *Podiatry in Australia- Background*. Retrieved 16 November 2012from website: www.podiatryvic.com.au/Podiatrists/Australia.htm

18. Dietitians Association of Australia. (2006). *Evidence Based Practice Guidelines for the Nutritional Management of Type 2 Diabetes Mellitus for Adults.* Dietitians Association of Australia, ACT. Retrieved 16 November 2012 from website: www.daa.collaborative.net.au/files/DINER/Guidelines%20endorsed%20by%20the%20%20Board%20(May)%20with%20tracked%20changes%20%20accepted(1)%20(2).pdf

19. Victorian Government Department of Human Services. (2007). *Diabetes self-management: Guidelines for providing services to people newly diagnosed with Type 2 diabetes.* Victorian Government Department of Human Services, Melbourne. Retrieved 16 November 2012 from website: www.health.vic.gov.au/pch/downloads/dhs_diabetes_guidelines.pdf