

Improving Coordination of Diabetes Care in Hume and Whittlesea

December 2018

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.

NH internal referral NH Diabetes Educator to Diabetes Educator, **no criteria required to be met** - considered "trusted referrer". Book as requested on referral. Any delay in booking greater than one week from referral, please email NHS-AmbulatoryDiabetes@nh.org.au to request an appointment time.

Table 1: HWPCP Diabetes Care Pathways

	Standard Pathway of Care	Intermediate Pathway of Care	Urgent Pathway of Care
Wait time for comprehensive assessment <i>Wait times are subject to demand. Please contact the provider directly for accurate wait times. Contact details are provided on the reverse side.</i>	14-56 days (2-10 weeks)	14-28 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 first 6 months, then quarterly-biannually	Weekly until stable, then monthly until discharge

Hume Whittlesea PCP Adult Diabetes Service Pathway

Stream	Eligibility (One or more ticks)	Where available	Provider details
<p>Urgent Pathway Brief intervention Stabilisation and transfer</p> <ul style="list-style-type: none"> • Immediate first appointment to Endo within 1-2 week. • DNE appointment to be made within 2-3 weeks to either NH or DPVH depending on the patient's location 	<ul style="list-style-type: none"> <input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <input type="checkbox"/> Recurrent hypoglycemia (unexplained BGL <4mmol >2 per week) - for outpatient appointment with a RN CDE/DE within a week from receipt of referral. <input type="checkbox"/> Active foot ulcer or wound - for outpatient appointment within 1 week from receipt of referral. <input type="checkbox"/> Recent pancreatic surgery or pancreatitis – for outpatient appointment within 1 week from receipt of referral OR as per discharge summary/referral. 	<p>Northern Health</p> <ul style="list-style-type: none"> <input type="checkbox"/> Priority appointment at NH <input type="checkbox"/> Endocrinology Clinic (MBS) <p>*DNE and DIET appointment can be made to either NH or DPVH depending on the patient's location. Endo appointment will remain at NH.</p>	<p>Northern Health (Central Intake)</p> <p>T: 1300 128 539 F: 9495 3510 www.nh.org.au</p>
<p>Intermediate Care Pathway (Type 1, LADA & Type 2 Diabetes)</p> <ul style="list-style-type: none"> • First appointment with the DNE within 4-8 weeks. • Endo appointment 8-12 weeks+ 	<ul style="list-style-type: none"> <input type="checkbox"/> HbA1c >8.5% (>69mmol/mol) with or without a hospital presentation/admission in the past 12 months <input type="checkbox"/> T1DM irrespective of HbA1c or BGLs <input type="checkbox"/> BGL >20mmol/L <input type="checkbox"/> Triglycerides >11.2mmol/L <input type="checkbox"/> eGFR <45 (mL/min/1.73m²) <input type="checkbox"/> T2DM requiring insulin or GLP-1 initiation or titration <input type="checkbox"/> Active foot pathology with a history of complications <input type="checkbox"/> Newly diagnosed T2DM not stabilised within 3 months <input type="checkbox"/> On corticosteroids (prednisolone and dexamethasone) regardless of HbA1c 	<p>Northern Health</p> <p>Dianella Plenty Valley Health (DPVH)</p> <p>Sunbury Community Health Service</p> <p>*Appointment can be made to NH, DPVH or SCH depending on the patient's postcode.</p>	<p>Northern Health (Central Intake)</p> <p>T: 1300 128 539 F: 9495 3510 www.nh.org.au</p> <p>Dianella Plenty Valley Health City of Whittlesea F: 9408 9508 City of Hume F: 8339 9898</p> <p>Sunbury Community Health Service T: 9744 4455 F: 9744 6777 www.sunburychc.org.au</p>
<p>Standard Care Pathway (Type 2 Diabetes – community health)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Newly diagnosed type 2 irrespective of HbA1c or BGLs <input type="checkbox"/> HbA1c ≤8.5% (≤69mmol/mol) <input type="checkbox"/> eGFR >45(mL/min/1.73m²) <input type="checkbox"/> No active foot pathology and no history of complications <input type="checkbox"/> T2DM requiring insulin or GLP-1 initiation or titration 	<p>Dianella Plenty Valley Health</p> <p>Sunbury CHS</p> <p>Medicare funded private allied health services</p>	<p>Dianella Plenty Valley Health City of Whittlesea F: 9408 9508 City of Hume F: 8339 9898</p> <p>Sunbury Community Health Service T: 9744 4455 F: 9744 6777 www.sunburychc.org.au</p>

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