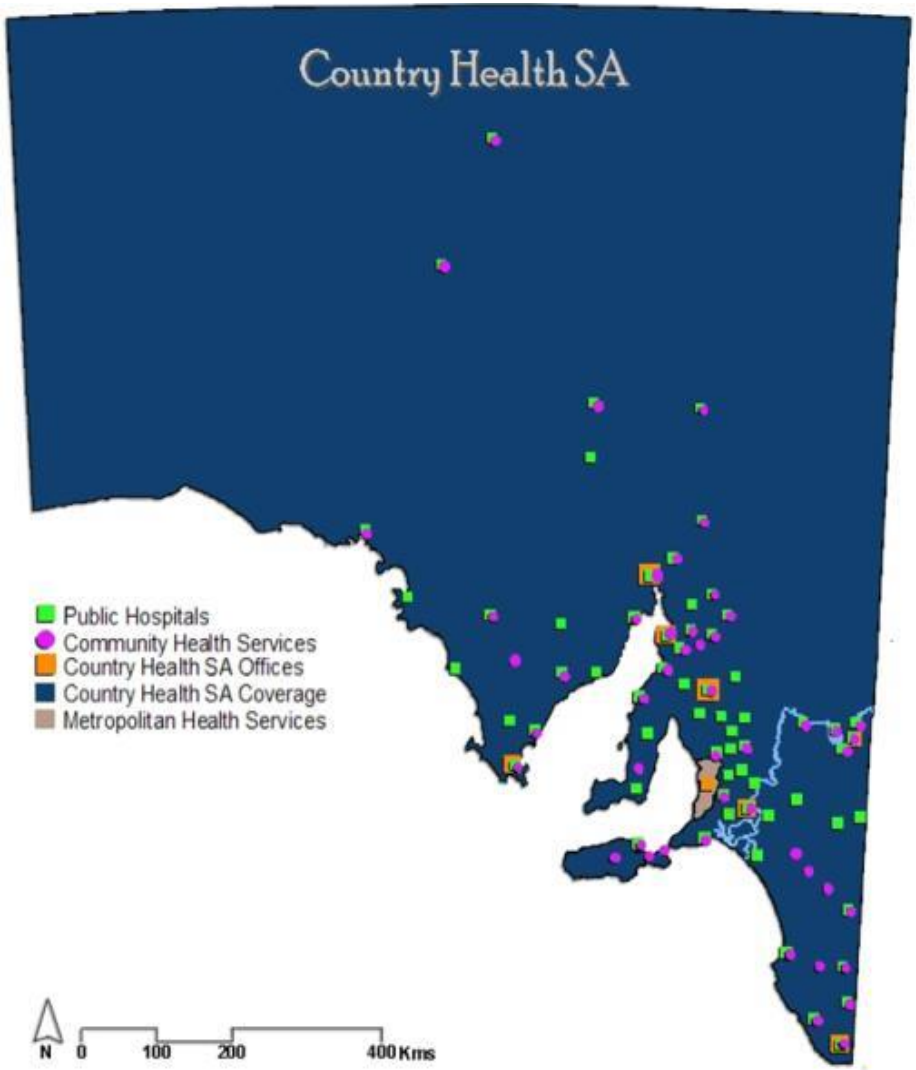
Diabetes Models of Care

NADC - BPDC 2017

Government of South Australia

SA Health

Country Health SA



- Single health network
- 1400 acute beds
- 600 aged care beds
- 64 hospitals
- CDE/DE 33 (20 FTE)
- Allied health workforce
- No employed Endo
- GP workforce
- Visiting private specialists

CHSA LHN Inpatient Diabetes Management and Model of Care – V18

KEY:
*– in development
**– Requires development
ADS: Australian Diabetes Society

GOAL: Optimise Intervention Opportunities

Pre-admission consideration
Can this service or care be provided in the ambulatory setting via Rapid Access Service?
- diabetes specialist nurse
- podiatry service
- endocrinology specialist
- BetterCare in the Community
- RIBS package

Emergency Department
SAAS (non transported call outs)
OPD

Planned admission
inc Pre-anaesthetics

Admitting Doctor
General practice / OPD

Diabetes Inpatient Scenario	Identifying and treating new hyperglycaemia in hospital	Admitted with diabetes as primary admission diagnosis eg. DKA, HHS, hypoglycaemia, hyperglycaemia (HbA1c >8.5%), diabetic foot ulcer	Diabetes as a secondary condition to admission diagnosis eg. infection, surgery, MI, pregnancy etc.
PROCEDURES	Screen at risk adults for hyperglycaemia as per NHMRC guidelines 1.Fasting or random plasma glucose 2.Routine capillary blood glucose measurements if on steroid therapy, MI, CVA, renal etc If blood glucose elevated, commence therapy as per relevant protocol.	1. Assess for transfer or retrieval to regional or metro hospital if needed. Consultation with endocrinology service or endocrinologist as per protocols 2. Implement appropriate CHSA protocols 3. Admission HbA1c or record recent (in last months) 4. Opportunistic complication screening (e.g. microalbuminuria)	1. Assess glycaemic status - Admission HbA1c or record recent (in last months) - Implement appropriate CHSA protocols 2. Type 2 - if BGL is elevated or there is anticipated hyperglycaemia, commence relevant protocol Type 1 - optimise insulin therapy or commence insulin infusion 3. Opportunistic complications screening (e.g. microalbuminuria)
REFERRAL CONSIDERATIONS	referral to diabetes service as per clinical priority tool. (phone consult an option) - pharmacist - diabetes specialist nurse - dietetic review - podiatrist BetterCare in the Community and external referrals as needed Home based PoC monitoring (HBGM and/or iPOCCS)		
CLINICAL MANAGEMENT AIMS	- Aim for target BGLs (as per guidelines) - BG management as per protocols - Minimise risk of hypoglycaemia, and treat as per protocol - Support safe self-management of insulin administration and blood glucose monitoring. Insulin pump therapy can continue only if it can be safely performed and monitored - Ensure adequate supervision and documentation of self-management - Foot risk assessment whilst person is in hospital (can be provided by trained non-podiatrist)		
DISCHARGE PLANNING & OUTPATIENT REFERRAL	GP for further screening if needed CHSA fact sheets - new diagnosis - long term care (cycle of care) Referral for diabetes service as an outpatient	Include diabetes in discharge planning considerations (review need for rapid follow up) Provide patient with relevant discharge information. CHSA fact sheets - new diagnosis - long term care (cycle of care) - hypoglycaemia action plan - hyperglycaemia (sick day) action plan - driving & diabetes - insulin therapy action plan - footcare action plan	

CHSA LHN PROTOCOLS

CHSA Diabetes clinical priority tool

NHMRC screening guidelines

Blood glucose/blood ketones monitoring chart

Hypoglycaemia management protocol

Hyperglycaemia Protocol and Insulin Dosing Chart

Diabetic ketoacidosis protocol

Hyperosmolar hyperglycaemic state protocol **

Insulin infusion protocol

Peri-operative management protocol (ADS)*

CSII Protocol and record chart

Diabetic foot ulcer protocol **

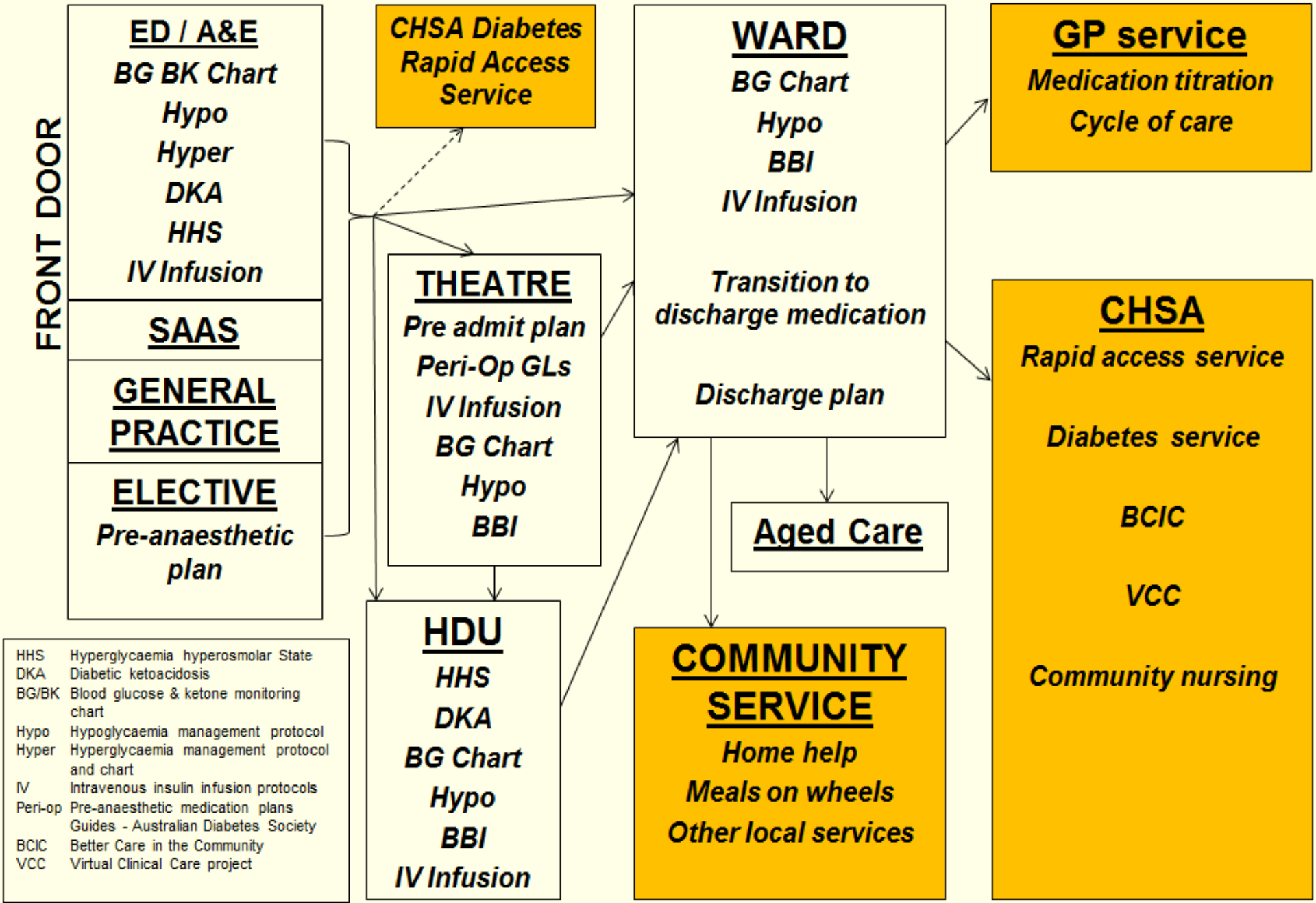
Foot screening protocol

See Community Model of Care

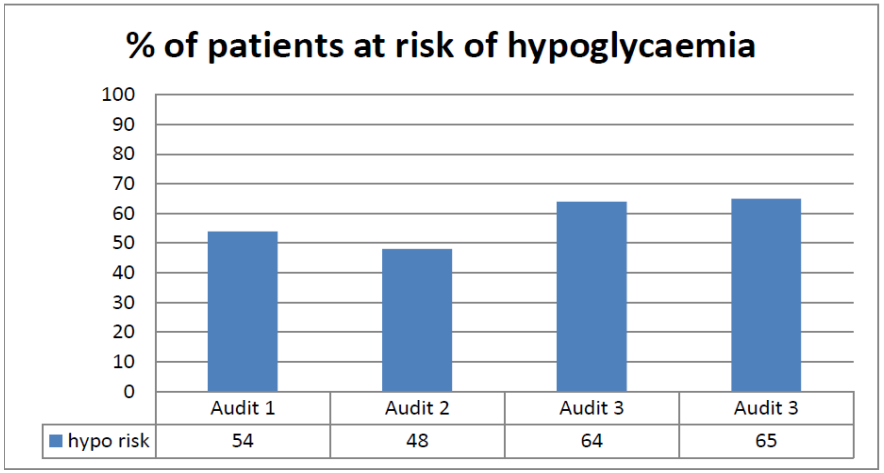
CHSA Diabetes Service Plan 2014 – 2018 amendment, p 19 – 23.

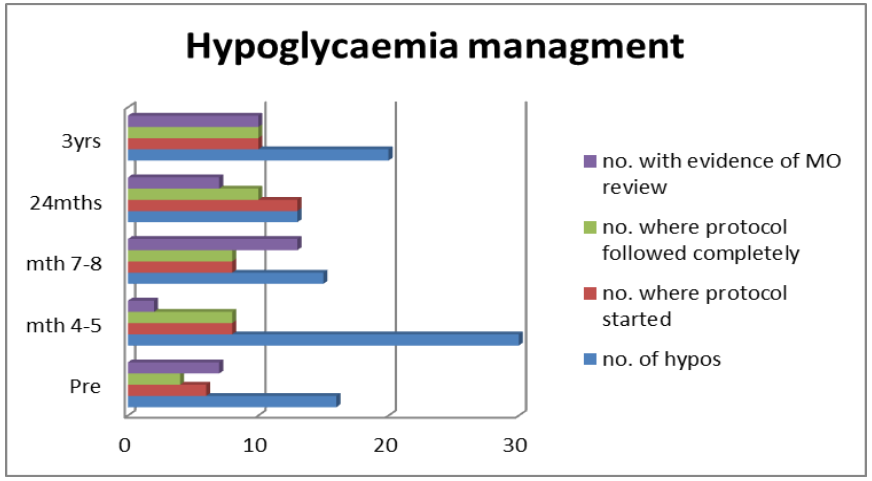
- Utilise telephone/video conferencing for inter-hospital access to specialist nursing or allied health.
- Utilise telephone/video conferencing for inter-hospital access to specialist medical advice.
- Admission summary to be sent to primary care general practitioner as soon as possible.

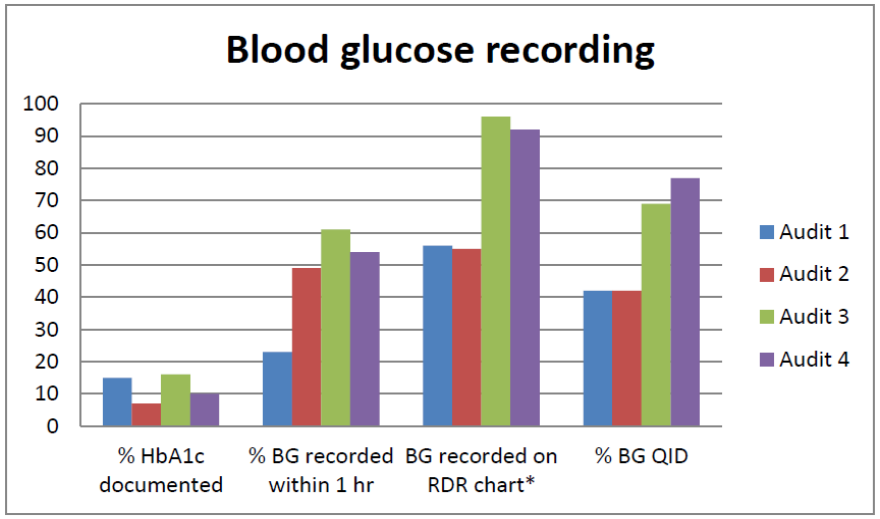
Inpatient Model of Care Patient Journey

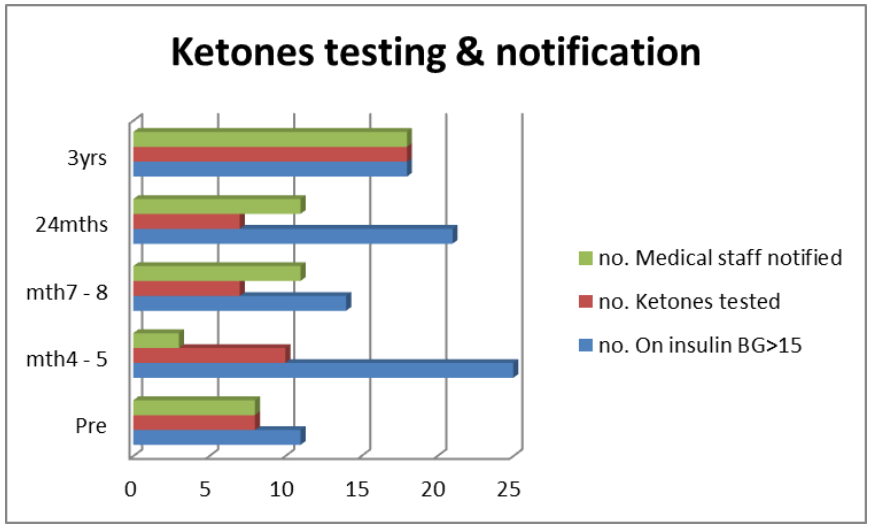


Inpatient audit data









Community Diabetes Model of Care_ DRAFT V11

KEY:
- NHMRC National Health & Medical Research Council
- GPMP General Practitioner Management Plan
- TCA Team Care Arrangement
- DSME Diabetes Self-Management Education
- CHSA LHN Country Health SA Local Health Network
- LGO Local Government Organisation

AIMS: Optimise clinical targets, minimise medical emergencies, engage and support self-management

At risk, impaired fasting glucose and impaired glucose tolerance

- Primary care programs: Awareness, health promotion, behaviour and lifestyle programs
- LGO / NGO / Public Health: Physical environments that support healthy behaviours

CHSA LHN diabetes clinical and self-management education service

DIAGNOSIS & ONGOING CARE

Primary Care: Chronic disease management programs

General Practice:
- Care as per NHMRC guidelines
- Cycle of care; type 1 and 2
- GPMP and TCA
- Urgent referral to specialist medical service for type 1 → shared care
- Primary medical care for type 2
- Annual review for type 2
- Refer for diabetes self-management education (CHSA LHN or private)
- Screening and uncomplicated (post education) management of gestational diabetes

Integration of services relevant to the local context

- Aboriginal Community Controlled Health Organisations
- Dept of Education and Child Services
- Non-government organisations
- Local government
- Other community service providers

Referral Indicators

For diabetes clinical and self-management education (diabetes specialist nurse, dietitian and podiatry services):
- Newly diagnosed diabetes – URGENT referral for type 1
- Paediatrics
- Gestational diabetes – urgent referral for new diagnosis
- Pre pregnancy and pregnancy
- Recent admission to hospital
- At risk foot or active problem
- Medical nutrition therapy
- Unstable diabetes (high risk of hospital admissions)
- Diabetes complication (high risk of hospital admission)
- Change or increase in medication therapy

Rapid access service utilised for patients at risk of hospital admission or follow up post discharge.

COMPLEX CARE

Specialist Medical:
- Primary medical management of Type 1
- Paediatrics
- Pregnancy in Type 1
- High risk pregnancy in Type 2
- High risk gestational diabetes
- Complex Type 2

Type 1	Type 2	Gestational
Diabetes specialist nurse: Triage as per CHSA LHN priority tool (Appendix) DSME provided as per education pathway (Appendix) Action plans based on individual risk profile Review cycle Annual/bi-annual review based on individual risk Shared care with specialist medical and primary care services	**Diabetes specialist nurse:** Triage as per CHSA LHN priority tool (Appendix) DSME provided as per education pathway (Appendix) Action plans based on individual risk profile Review cycle Review based on *Referral Indicators*	**Diabetes specialist nurse:** Triage as per CHSA LHN priority tool (Appendix) DSME provided as per education pathway (Appendix) Review cycle As per SA Health Perinatal guidelines Shared care with midwife/obstetric services/GP
Dietetics: Newly diagnosed Basal bolus insulin and pump therapy Advanced carb counting Pregnancy planning Paediatrics Other nutritional complexity as per clinical priority tool (Appendix) Annual/bi-annual review	**Dietetics:** Review at commencement of basal bolus insulin / pre-mix Review on exacerbation of complication (eg renal) Advanced carb counting Pregnancy planning Paediatrics Other nutritional complexity as per clinical priority tool (Appendix – list of potential complexities?)	**Dietetics:** Initial & review during pregnancy As part of multidisciplinary team

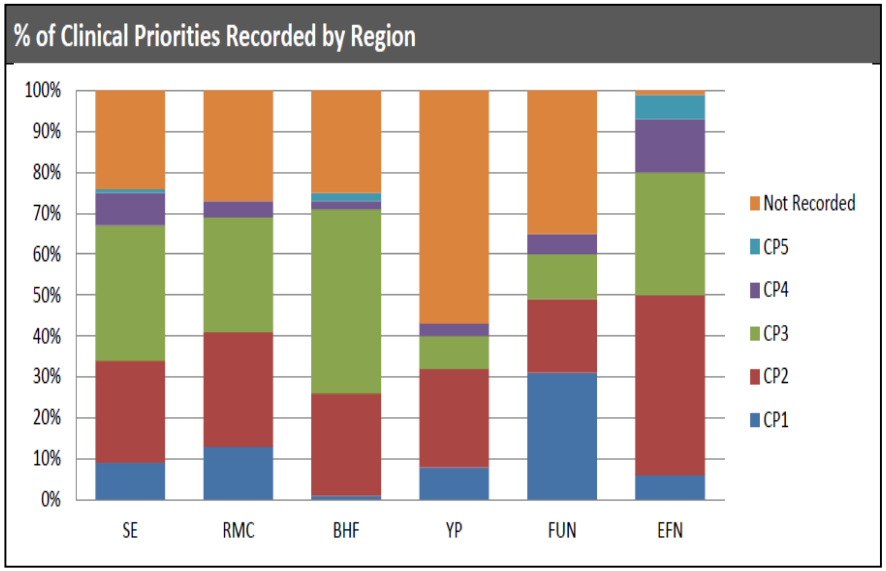
Podiatry:
Review of at risk feet as per CHSA LHN Podiatry assessment tool
Foot care action plans for low risk
Foot protection plans for at risk
Assess and treat active foot pathology
Interdisciplinary neurovascular screening – training and support
Other as per CHSA LHN priority tool

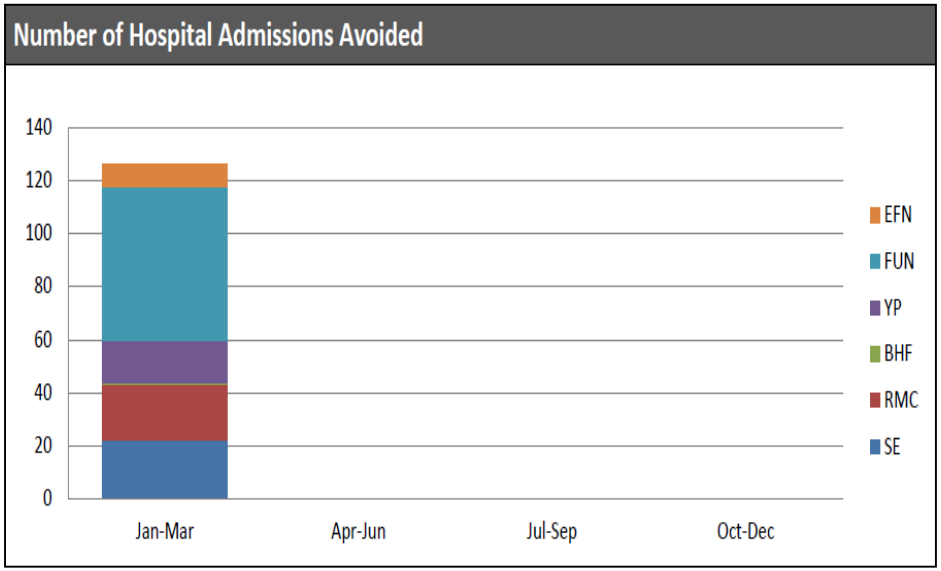
Multidisciplinary services:
Refer as needed for clinical and cultural needs to appropriate allied health professionals e.g. psychology, Aboriginal health and chronic disease support services

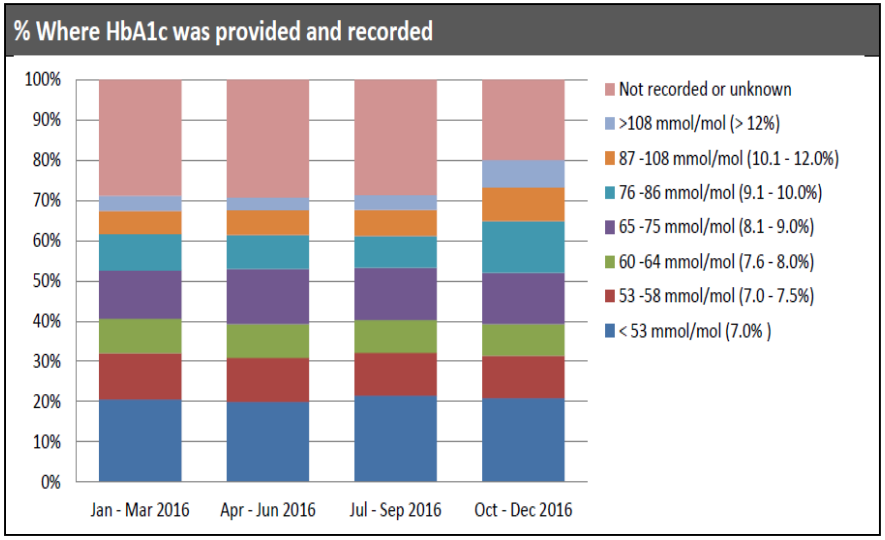
STANDARDISED CHSA EDUCATION RESOURCES & CLINICAL PATHWAYS

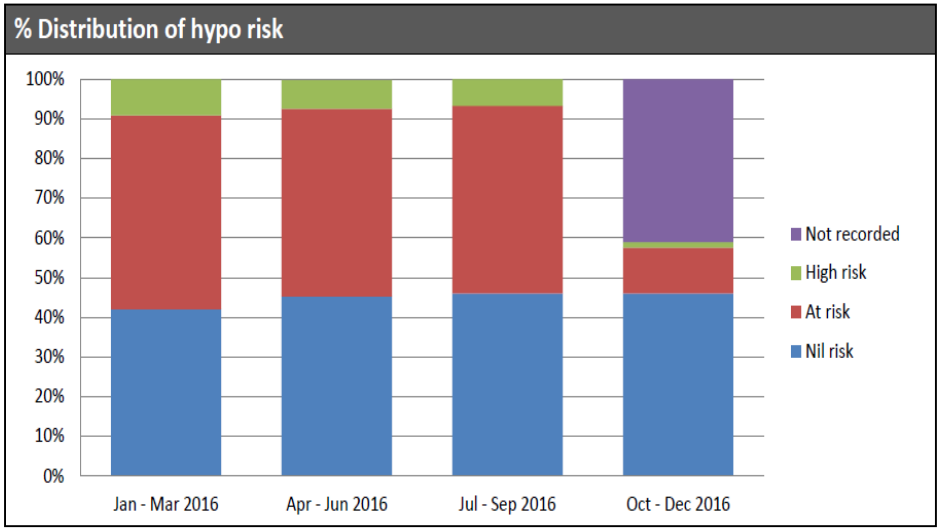
COMMUNICATION SYSTEMS: Telephone / video conferencing, secure email, clinical decision support mechanisms

Outpatient/community audit data









What are our challenges/concerns

- Lack of a SA Health implementation plan for the National Diabetes Strategy.
- Workforce - Diabetes specialist nurse positions under threat – interpretation of chronic disease model in community health focuses on generalist HCPs.
- Lack of specialist endocrinology specific to CHSA. Lack of systematic approach to stratifying clinical support for contracted GPs, eg partnerships with metropolitan health units.
- Poor support for clinical VC models – eg expectation of using boardroom/meeting room as a clinical workplace.

The central team

Jane Giles	Advanced Nurse Consultant – Diabetes, CHSA
Collette Hooper	Nurse Practitioner – Diabetes, CHSA
Barbara Cummins	Project Administration Officer (0.6FTE)

Country Health SA Diabetes Service

Go to www.chsa-diabetes.org.au

Email chsa-diabetes@health.sa.gov.au

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