Diabetes Integrated Team

Memorandum

DATE:	4th December 2023
TO:	GP Practices and Māori health providers
FROM:	Brenda Szabo, Diabetes Integrated Service Lead
COPIES:	Diabetes Service Operational Group (DSOG) Diabetes Service Level Alliance Team (SLAT)
SUBJECT:	**DIABETES INTEGRATED TEAM** - **REFERRAL CRITERIA CHANGE** - **BPAC PATHWAY CHANGE** - **VACANCIES AND REDUCED SERVICES**

Tēnā koutou

We would like to update you that the referral criteria and referral pathway for the clinical teams in the Diabetes Integrated Team (DIT) is changing. The purpose of this change is to ensure that this team is moving towards the Taranaki Diabetes model of care that was developed by the Diabetes Alliance across Te Whatu Ora, Pinnacle Midlands Health Network, Ngāti Ruanui, Ngāruahine and Tui Ora.
The principle functions that underpin the team are:

1. **Comprehensive clinical and Psychosocial Intervention –** providing clinical and psychosocial expertise when it is needed to directly manage patients with diabetes with the aim of discharging them back to primary care as appropriate.
2. **Provide enhancement and capability support** - by providing support education and training for health professionals and patients, guided by the needs of primary care and Māori health providers and secondary care teams, to ensure patients with diabetes receive high quality and consistent clinical care and health information.

The referral criteria has been updated for our Diabetes Clinical Nurse Specialists (CNS) and Diabetes Specialist Dietitians (please refer Appendix 1). The most significant changes being made is to limit referrals for those with type 2 diabetes to those with the most significant clinical need. As part of this referral criteria change, we are also transferring (back to GP) patients that have stable diabetes management and no longer meet the referral criteria.

This change will then enable the team to have greater capacity to achieve function 2 (above) of the model of care.

In addition to this, in early January 2024 we are moving to ONE referral to the DIT team through BPAC (Appendix 2). This means that there will be just one referral to select within BPAC for the DIT, and the Diabetes CNS and Foot Protection Service (FPS) queues will be inactivated. It will be assumed that when the referral is sent, the patient is consenting for all services within the DIT team.

Where then, do my patients that have Type 2 diabetes and don't meet the criteria, get optimised diabetes management?

- General Practice / Māori Health Provider – GP and Practice Nurse
    - Refer guidelines on NZSSD Type 2 Diabetes Management Guidance - New Zealand Society for the Study of Diabetes (nzssd.org.nz)
- Diabetes Community Co-ordinator (Diabetes NZ)
- Long Term Conditions nurses (Tui Ora, Ngāti Ruanui, Ngāruahine)
- Pinnacle Extended Care Team
- Kaitautoko Mate Huka (Appendix 3)

How can my practice access support or upskilling if our patients are not meeting criteria for entry into the Diabetes Integrated Team?

- Contact your Diabetes CNS allocated to your cluster to arrange education sessions and upskilling, or to seek advice (Ph: 06 7537707).
- Contact the Diabetes Integrated Service Lead (Brenda Szabo) to facilitate upskilling by members of the DIT (Ph: 0278366501)
- Liaise with your Pinnacle Nurse lead (Jessica Knight – Ph: 0272411050)

Vacancies and impact on services

We currently have vacancies within the Diabetes CNS team and the Foot Protection Service. This may impact on the timeliness of patients being seen. Please do not hesitate to reach out if you require a patient to be seen earlier, or if their situation has changed and they need further services involved in their care, or they have moved to a higher priority.

DIT referrals: Phone 06 7537707

Foot Protection Service: All urgent referrals are encouraged to telephone as well as refer. Ph 027 289 1559 (Rebecca Holbrook) or 06 753 7748.

We hope you had a rested Christmas and New Year period, and look forward to working with you in 2024.

Ngā mihi nui,

Brenda Szabo

Interim Diabetes Integrated Service Lead, Taranaki

Appendix 1 – Change to Diabetes CNS and Specialist Dietitians referral criteria

Clinical Nurse Specialist

- Newly diagnosed Type 1 diabetes
- Patients on, or wanting to commence, insulin pump therapy
- Type 1/Type 2 diabetes in youth 15-25 years of age (youth and young adult clinics)
- Requiring insulin titration to manage high dose glucocorticoid therapy
- Absolute insulin deficiency due to absent pancreatic function
- Type 2 diabetes
    - on optimal medication, but HbA1c remains >80mmol/mol
    - recurrent (weekly or more) hypoglycaemic events on insulin or sulphonylurea
    - under the care of the renal team and requiring additional diabetes CNS input not able to be provided by the renal CNS
- Women with type 1 or type 2 diabetes who are planning pregnancy
- All diabetes in pregnancy

Diabetes Specialist Dietitian

As above, plus:

- Type 1 diabetes with other nutritional concerns (e.g. weight management, gastroparesis, nutritional deficiencies)
- Early GDM – HbA1c of 41-49mmol/mol

Appendix 2 – Diabetes Integrated Team BPAC referral information box

Diabetes Integrated Team

Service Detail

The Diabetes Integrated Team (DIT) is a multi-professional collaborative of providers in the Taranaki region. This multi-organisational team is committed to improving health outcomes and health equity for people living with diabetes (PWD) through comprehensive clinical and psychosocial intervention and providing enhancement and capability support.

Eligibility Criteria

This service is for adults (>15 years of age) who meet one of the following criteria

Clinical Nurse Specialist

- Newly diagnosed Type 1 diabetes
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Foot Protection Service

Active Risk – *Any of the following. These are urgent - please phone as well.*

- Foot ulcer
- Spreading infection
- Critical ischaemia
- Gangrene
- Hot, swollen foot with/or without pain (possible active Charcot foot)
- Post-operative including open wound

Foot Risk symptoms

- Signs or symptoms of peripheral arterial disease
- Previous lower limb arterial interventions
- Loss of sensation
- Significant callus
- Significant foot deformity
- Pre-ulcerative lesion
- eGFR <15 (CKD Stage 5)
- Māori ethnicity

Appendix 2 – Diabetes Integrated Team BPAC referral information box – continued…

Alternative Pathways

- PWD who do not meet the referral criteria above may be considered for other services such as Long Term Condition nurses, Pinnacle Extended Care team (refer directly to these services within BPAC)
- Māori PWD who do not meet the referral criteria for the disciplines above, may still meet the criteria for the Kaitautoko Mate Huka (refer specifically to this pathway within BPAC)
- Children living with diabetes (0-15yr) – refer to Paediatric Service

Referral to include:

In order to provide an appropriate and timely response, referral to include:

- Most recent blood test results (HbA1c, electrolytes, creatinine, CBC, ACR, TFTs, LFTs, Lipid profile) within 3 months
- Steroid therapy plan (if applicable)
- Blood sugar checks of x 4 per day for at least 4 days
- BP/weight/height/BMI
- Last foot screen results, DAR results (add as attachment)

For pregnancy in addition to the above we need:

- Antenatal booking bloods
- OGTT/polycose glucose challenge results
- History to detail any previous GDM, previous birth outcomes of concern and any family history of diabetes

Appendix 3: Kaitautoko Mate Huka referral criteria

Service Detiail

The Diabetes Kaitautoko Mate Huka is a cultural support worker, navigator and health coach for whānau Māori living with Diabetes. The aim of this non-clinical role is to engage and support Tangata Māori to achieve better control of their diabetes and therefore achieve better health outcomes.

The Kaitautoko Mate Huka supports Tangata Māori to bridge the gap between themselves, general practice, hospital and specialist services and the community. They provide support, information and connections for individuals, groups, and families for both mental health and physical health conditions in people of all ages with a focus on living well with diabetes.

These roles form part of the Diabetes Integrated Team who provide oversight and guidance and are strongly linked to the Whānau Ora principles. Through the use of digital tools, the Kaitautoko will enable the person living with diabetes to better understand their health needs and achieve their health goals.

Tangata Māori with elevated HbA1c and Whānau Māori not engaged with the system will receive priority access to this service.

The Kaitautoko Mate Huka provide care closer to home and operate the three Māori health organisations plus Pinnacle Midlands Health Network to provide whanaungatanga, kaitiakitanga and manaakitanga:

- Tui Ora
- Ngaruahine
- Ngati Ruanui

Eligibility Criteria

Any Māori whaiora with Type 1 or Type 2 Diabetes Mellitus with:

- HbA1c >80mmol/mol aged over 15 years
- New diagnosis of diabetes
- Currently not engaged/disengaged with healthcare provider
- Who would benefit from the service

By discretion only / case by case basis:

Any Māori patient with diabetes

- Under 15 years
- Patients with diabetes in pregnancy