DIABETES—TRIAGE GUIDELINES FOR INITIAL APPOINTMENTS

URGENT (within 48 to 72 hours)	SEMIURGENT (within 1 to 2 weeks)	ROUTINE (within 1 month)
One or more of the following: **Glycemic Control*** • BG > 20 mmol/L • A1C ≥ 10% • New type 1 diagnosis (any child/youth) • Recent treatment of DKA, nonketotic hyperosmolar hyperglycemia • Severe hypoglycemia (recurrent/uncontrolled) • Pregnancy with preexisting diabetes • Recent discharge from hospital following insulin start/New Diagnosis/ Acute Coronary Syndrome • Insulin start A1C ≥ 10% **Dyslipidemia**** • TG >10 mmol/L***	One or more of the following: **Glycemic Control*** • BG 15 to 20.0 mmol/L in a new diagnosis • A1C 8.5% to10.0% in a new diagnosis • Recurrent hypoglycemia **Nephropathy** • eGFR ≤ 30 ml/min **Other** • Gestational diabetes (within 1 week) • DM with recent diagnosis of celiac disease • Diabetes requiring optimization in presence of uncontrolled risk factors for CVD and elective surgery	**Most likely require one-on-one visit** • Insulin pump therapy • Preconception Planning • Continuous Glucose Monitoring (CGM) • Transition from Pediatric to Adult care All other patients to have initial appointment within one month* • Dyslipidemia** • Hypertension**** • Insulin start A1C 7.0% - 8.4% • Self -management education or difficulties managing DM and not able to be managed in the community. Consider Community Lifestyle Programming • Prediabetes - FBG 6.1-6.9 or 2hr PG 7.8-11.0 mmol/L

Crisis that affects an individual's ability to manage this/her DM (urgent to semi-urgent)

* Patients with any level of dysglycemia will attend a Survival Skills Module. Assessment for individualized treatment plan will follow.

Community chronic disease programs should be considered for the following:

** Patients with elevated lipid levels will attend a Heart Health Module; prior initial assessment not required to attend.

*** Patients with markedly elevated or severe hypertriglyceridemia will be seen by dietitian only; follow up with primary care physician

**** Patient who is hypertensive will attend a Hypertension Module; prior initial assessment not required to attend.

Example for use of the initial appointment guidelines:

Mr. B. is a 53 year old with type 2 diabetes, 3 years duration, and new to your DC. FBG 9.2 mmol/L; A1C 7.9%; using non-insulin therapy; dyslipidemia; and hypertension.

Plan: Patient will attend the next scheduled survival skills (< 1 month); heart health and hypertension modules; individual appointment for initial assessment with RN and PDt will follow. Mr. B. will receive in advance a self-assessment form to be completed prior to initial visit. Lab work should be done prior to initial assessment if no recent results available.

Community-based, patient-centered, culturally appropriate programming is a key component of diabetes care.

DIABETES TRIAGE AND DISCHARGE CRITERIA—GUIDELINES FOR FOLLOW-UP & DISCHARGE (FOLLOWING INITIAL APPOINTMENT AND/OR INTERVENTION PERIOD)

	1 to 2 MONTHS [1]	3 to 4 MONTHS[1]	6 MONTHS[1]	DISCHARGE
HEALTH STATUS	**Persistent Hyperglycemia** • Requires a change in treatment • Recent start of new medication • Insulin start A1C ≥ 9.0% • TG ≥ 10 mmol/L • Urgent request of physician to address a knowledge or skill deficit	• Significant weight gain	• Type 1 DM (young adults & transitioning youth) • NSIPP individuals (2x visits/yr)	• A1C < 7%; or, in the presence of those with DM of long duration/multi-morbidity, at established A1C target (liberalized with patient and provider). • Good metabolic control or showing a consistent improvement in A1C and lipids. • With the following in place: o Demonstrated good understanding/application of diabetes self-care practices o Established health care network and supports o Established self management/problem solving skills o Ability to articulate when re-referral would be beneficial
METABOLIC CONTROL	**Glycemic Control** • Severe or frequent hypoglycemic events • Recent DKA • A1C ≥ 9.0%	**Group/Individual Follow-up** • A1C 9.0% • Dyslipidemia • Address a specific self-care management skill • A1C completed every 3 months when glycemic targets are not met and pharmacotherapy in being adjusted	**Group/Individual Follow-up** • A1C 7.0% to 8.9% • Evidence of complications • High-risk foot • TG 4.5 - 10.0 mmol/L • TC/HDL ratio > 4.1 • LDL-C > 5.0 • Systolic BP > 180 Hypertensive patients receiving lifestyle modification advice alone (CHEP 2014)	• Follow-up to continue with primary care provider. • Treatment goals must be tailored to the individual with diabetes, with individual risk taken into account.

[1] *Note: Routine blood work to be done 10 days prior to clinic appointment.*

Pregnancy Follow-up: As required throughout the gestational period.
Frailty: Special consideration should be given to the A1C and Blood Glucose (BG) targets in the presence of frailty. Use of the Clinical Frailty Scale is recommended to help determine when to use the DCPNS Guidelines for Frail Elderly Residents in or Awaiting Long-Term Care.

EXAMPLE FOR USE OF THE FOLLOW-UP APPOINTMENT & DISCHARGE GUIDELINES

Plan: In the presence of dyslipidemia, adequate understanding, and good metabolic control, Mr. B will return for 3-4 month follow-up (group/individual).

Plan: In the presence of an A1C of 7.5% (at individualized target), a good understanding of diabetes self-care practices, and knowing when re-referral may be appropriate, Ms. K is being discharged today. A letter will be sent to the referring care provider and Ms. K will receive a written copy of Staying Healthy with Diabetes and summary of her treatment plan (when to access care).

References:

- Canadian Diabetes Association Clinical Practice Guidelines Expert Committee. Canadian Diabetes Association 2013 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada. *Can J Diabetes.* 2013;37(suppl 1):S1-S212.
- Clinical Frailty Scale©. Dalhousie University Faculty of Medicine Geriatric Medicine Research web site http://geriatricresearch.medicine.dal.ca/clinical_frailty_scale.htm 2007-2009. Version 1.2 Accessed March 7 2016.
- Dasgupta, K, Quinn RR, Zarnke KB, et al. The 2014 Canadian Hypertension Education Program Recommendations for Blood Pressure Measurement, Diagnosis, Assessment of Risk, Prevention, and Treatment of Hypertension. *Can J of Cardiol.* 2014; 30(5):485–501.
- Diabetes Care Program of Nova Scotia. *Pregnancy and Diabetes Guidelines: Approaches to Practice.* Halifax, NS: Author; *2014.*