Diabetes Care Program of Nova Scotia (DCPNS)

Triage and Discharge Guidelines for Initial and Follow-Up Appointments in Diabetes Centres (DCs) in Nova Scotia, 2016

Frequently Asked Questions (FAQs)

Background:

The health system is changing and with this the number of supports available to people living with diabetes is increasing across the province. Expanding Primary Health Care Teams are growing expertise in general diabetes care and education and Community Health Teams provide wellness programming that is of benefit to many living with diabetes.

Depending on available community and primary care supports, Diabetes Centres (DCs) may provide a wide range, or a more focused approach, to the services they offer. DC Services include:

- Individual and group education/support for all types of diabetes— providing the necessary foundation for diabetes self-management knowledge, skills, and behaviours;
- Routine review and revision of treatment plans and individual progress (monitoring for complications development and/or progression);
- Collaboration with the primary care provider to introduce and adjust treatment plans (e.g., insulin initiation a adjustment, nutrition therapy/CHO counting, etc.); and
- Care and education of special populations including pediatrics, pregnancy, insulin pump users, and individuals with diabetes complications requiring advanced skills— kidney disease, gastroparesis, severe hypoglycemia and hypoglycemia unawareness, etc.

Due to the variety of services a program may provide and the populations they may see, Triage Guidelines will help ensure patients are seen appropriately, in a more-timely manner.

Why is it important to have Triage and Discharge Guidelines?

An increase in the number of people living with diabetes, often with more complex needs, and growing caseloads in DCs make the Triage Criteria a valuable tool. Patient safety and readiness, with a focus on self-care and appropriate discharge, are key components of these guidelines.

- Clinical Practice Guidelines reinforce the need for **timely, tailored, and appropriate self-management education** to enhance self-management skills, including problem solving and goal setting.
- **Individualization of treatment plans and glycemic targets** are now recommended. Individualization takes into consideration the type of diabetes and its treatment, degree of dysglycemia and other metabolic abnormalities, duration of disease, life expectancy, and the presence of comorbidities including hypoglycaemia.
- **The earlier introduction of, and more rapid titration** of insulin and a growing selection of new and combination therapies, requires intensive and focussed diabetes educator support over specified periods of time.

What is the purpose of these guidelines and the discharge criteria specifically?

These guidelines are intended to ensure safe, timely access for new referrals and time-intensive individuals and to ensure follow-up that promotes and encourages the development and application of self-management skills. It is recognized that complex and time-intensive individuals require more focussed attention (a case management approach), and more frequent follow-up during specified periods of time.

Discharge to the primary care provider is intended to foster self-care, keep workloads manageable, and to allow diabetes educators to focus on time-intensive cases, where needed. Discharge using a shared care lens ensures that the patient and the provider understand the times and pivot points when re-referral/access to a specialty diabetes team would be beneficial (timely).

Why are discharge criteria a necessary part of this tool and when do we discharge patients?

There are currently more than 100,000 people living with diabetes in Nova Scotia and the number continues to grow. Discharge criteria are an essential part of managing our very important resource (DCs), moving individuals toward independence and more confidence in self-care, and freeing up time to provide a different kind of support to more complex/time-intensive individuals.

The updated Triage Guidelines do not differ that much from my current practice…

In 2003, the DCPNS developed guidelines for initial and follow-up appointments, and in 2009 these were reviewed and revised. Since the initial release, a number of DCs in NS have adopted the Triage Guidelines for use within their practice setting. The guidelines have been used when triaging referrals, extending time between patient visits (visits based on metabolic control), and in some cases, to support discharge.

The 2016 version of Triage and Discharge Guidelines have the same look as the previous guidelines and should be familiar to most working within DCs. This most current version has added a few new considerations (i.e., recent discharge from hospital with Acute Coronary Syndrome) with a much stronger (articulated) focus on appropriate discharge from DCs. These changes are intended to allow for better support of more complex (time-intensive) cases within the time and resource limits of existing DCs.

How do we apply the Triage Guidelines and timelines to part-time clinics?

For some part-time programs, this is a very real concern. However, this creates an opportunity to clearly define the appropriate referral pathway for the most urgent cases. There may very well be individual cases that will need to receive assessment and initial education at a larger, more regional program (one that operates more frequently and is able to accommodate an urgent referral). The follow-up could/should be back in the part-time clinic if it is more convenient for the patient/family. The development of these partnerships between regional and smaller local sites, emergency departments, local dietitians, and other programs or teams is the best way forward to meet the immediate needs of urgent and semi-urgent referrals for part-time clinics.

Following the lead of clinics that have successfully blocked appointment times for urgent and semi-urgent referrals, and implementation of group learning is highly recommended to allow quicker access to necessary care.

We often receive referrals with A1C greater than 10%. How do we manage this?

If not newly-diagnosed, these individuals are being referred a bit late in the game. It is beneficial to have newly diagnosed individuals attend DCs soon after diagnosis to gain foundational self-management knowledge, skills and behaviours to help manage their own health and diabetes.

This tool may present an opportunity to work with your area's referring health care providers. These providers may be holding these individuals for referral until they feel they are more advanced in their diabetes; they may actually perceive that the wait time to access the program for less advanced diabetes is longer than the reality. Ask yourself, is there a pattern? Are they coming from select care providers where communication about the services offered by the DC might be helpful (review of wait times, services offered including group teaching to allow quicker access, approach to triage, etc.)? Remember that getting individuals early in their diagnosis (during so called "teachable moments") provides the opportunity for a solid introduction to diabetes self-management education.

If you are regularly receiving large volumes of referrals with an A1C >10%, look for opportunities to offer programs or group sessions that allow these referrals to be booked within a timely manner.

What do we do with a "not newly diagnosed" new referral that has a long-standing history of A1C values > 10%, do we still treat this referral as an urgent referral?

We feel it is best to keep the guideline at 10% as indicated, but do encourage some clinical judgement.

During this revision, an A1C of 10% was maintained as "urgent" due to support within the literature. An A1C of 10% is considered urgent for anyone with DM even if he/she has long-standing diabetes. The argument can be made that a long duration of a high A1C levels may be of greater urgency due to the risk of acute and chronic complications. It is always up to you and what you know about the history of this type of patient, as to how you ultimately class this referral (urgent or semi-urgent).

Why do women with gestational diabetes require an initial assessment within one week?

Gestational Diabetes (GDM) is a time-sensitive condition with a relatively short timeline to achieve very tight glycemic targets. If the referral is late, any delay in initiating the treatment plan may have adverse outcomes. If the referral is early, and timely, 1-2 weeks may be acceptable. In the case of multiple GDM referrals at one time, phone contact may be of some assistance to start lifestyle change and the required monitoring. Some triaging of these referrals may also be possible based on weeks gestation, 75gram OGTT results, etc.

Who will be discharged?

Individuals who are well managed and/or comfortable with and/or supported to self-manage at home and within the community will be discharged from the DC. At the time of discharge, emphasis will be placed on having the individual understand the importance of regular visits with their primary care provider (2 or more times a year) for assessment of their diabetes, a review of their treatment plan, and to test for the development/progression of potential diabetes complications. *See draft patient letter.*

When using the discharge criteria, does the patient need to meet all the criteria?

The discharge criteria provide guidance around when to discharge back to the care of primary care provider for routine diabetes follow-up. The two key criteria focus on A1C and metabolic control (either at goal or showing consistent improvement). Once these are met, the other conditions should be in place to support sustained improvement. Obvious deficits (i.e., self-management skills and supports) should be explored/mitigated prior to discharge. This could be accomplished with some specific sessions/modules focused on self-care, expectations regarding routine care for diabetes, linkage to community supports/programs, etc.

My patient has great diabetes management practices and is to target, but likes to come to the DC and is requesting an appointment once a year. Do we still discharge this patient?

Yes, clients with well-managed metabolic control and the ability to self manage should be discharged. Encourage this patient to look for other opportunities for support within the community, such as a Your Way to Wellness program, community information sessions, or other community supports.

Remember, reducing your overall caseload allows you to offer a case management approach to those who require more immediate support to actively manage their diabetes.

Should clients with type 2 diabetes using insulin therapy be seen in follow-up at least once a year regardless of A1C level?

Discharge of patients should be based on metabolic control as outlined in the criteria above. Ensuring people know when to re-access the DC staff should help you in this decision.

Once patients are discharged, can they return to the Diabetes Centre?

Before implementing the discharge criteria, every effort should be made to engage and communicate with your referring health care providers and your patients. Discharge should be thoughtful and seen as a positive step for patients. They should also know when and how they can re-access your services if needed and what this process looks like. In some areas, self-referral may be acceptable to the primary care provider, in others re-referral may be needed. The triage guidelines provide guidance for re-referral—including marked deterioration in blood glucose, need to initiate insulin or pump therapy, pregnancy, severe hypoglycaemia, crisis affecting his/her ability to self-manage, etc.

We have a patient who is not able to achieve A1C target per clinical guidelines but has reported that current BG levels are to target (per patient set targets). Do we discharge this patient?

Treatment goals must be tailored to the individual with diabetes, with individual risk taken into account. Understanding these treatment goals and how they have been set may help you in your discharge decision. It is important to ensure appropriate communication with regards to self management and care, the need for routine assessment and recommended follow up; as well recommendations as to when to reinitiate contact and referral to DCs.

Are there individuals that should not be discharged?

Ideally young adults with type 1 diabetes should maintain close contact with the health care system. This population should not be discharged, but could be offered an extended time between appointments (6-12 months), if receiving care from a specialist physician. Individuals participating in NSIPP also require the ongoing support of a specialty diabetes team (2x/year).

Other

Specific Example (using clinical judgement)

A new referral is received and the referring A1C is > 10%. In conversation with the person on the phone, he states that his HCP had started him on an oral agent at diagnosis. He reports that his home tests are much improved. How do we triage this referral?

This person is no longer urgent (based on the most recent information provided by the patient). In conjunction with the patient, consider offering semi-urgent or routine care (maximum wait time 1 month). Remember, diabetes self-management education should still be priority.

We have a large number of referrals that have A1C levels between 8.5-10%. What should our approach be?

This might be a great opportunity to introduce a group to address "core" or survival skills. An individualized plan should still be the goal, but could happen following the group education.