DIABETES CARE COORDINATION PATHWAY

Diabetes Management Clinic
Referral received from CDM Intake

Sign and return GP-TCA Care Plan and return to referring GP

CARE PLANNING

Care Planning

Initiate a client care plan +/- other HP input as relevant for care plan contribution ie Dietitian, Social worker, Physiotherapist, Occupational Therapist etc. Care Plan may be service specific, multidisciplinary (intra-agency) or interagency, and should include the following elements;
Issue/problems
Goals, actions, target dates, responsible agents
Regular review dates
Participants
Checklist-evidence of need
Method of planning

CLIENT ASSESSMENT

Conduct comprehensive client assessment

- Anthropometric measurements (Wt, BMI, Waist Circumference)
- Assessing diabetes knowledge
  - -confidence and skills to manage diabetes (self-efficacy)
  - -managing blood glucose levels
  - -assessing lifestyle risk factors
  - -assessing coping skills and social supports
  - -screening for mental health issues

(1 x 1 hour consultation)

SELF MANAGEMENT PROGRAM

Self Management Program

Attend 2 hour Diabetes Education Session
Enrol in Better Health Self Management Program 6 week x 2 hour group program
or
Clients not suitable for groups will have access to 3 x 45 minute individual appointments with the Diabetes Educator)

Provide feedback letter and/or care plan feedback to GP

COMMUNITY LINKAGES

Link client into appropriate community programs, networks or clubs as appropriate to support maintenance of a healthy lifestyle.

CLIENT MONITORING

Client Monitoring

Clients to be followed up at 3, 6, and 12months by Diabetes Program Worker and other appropriate HP's as relevant, including;
Follow up of individual issues
Provision of specific allied health services (eg dietetics, podiatry etc)
Provision of lifestyle support and diabetes advice
Liaison with GP
(3 x ½ hour consultations)

Provide feedback letter and/or care plan feedback to GP
To occur at each client intervention point

Ongoing Management

Discharge planning is undertaken with clients throughout the program and discharge is to occur when the client meets all criteria as identified in CDM Program Guideline 1.1.7 Transition and Exit.