MODEL OF CARE

Enhanced annual cycle of care for high risk diabetic patients

PRACTICE NURSE
Determine eligibility criteria

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PRACTICE NURSE
Identify eligible patients

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GP
List of eligible patients reviewed

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PRACTICE NURSE
Patients recruited to the project

↓

GP & PATIENT
Patient consent to participate in project

↓

GP, PRACTICE NURSE, PATIENT
Commence enhanced cycle of care

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PRACTICE NURSE
Commence regular nurse contact

↓

GP & PRACTICE NURSE
Enhanced cycle of care completed

COORDINARE acknowledges the work done by Illawarra Family Medical Centre in developing this model of care

MODEL OF CARE

Enhanced annual cycle of care for high risk diabetic patients

Criteria was diagnosed Type 2 diabetics with associated risk factor

- Patients with diagnosis of Type 1 or Type 2 diabetes and any of the following;
  - HbA1c > 7.5%
  - Established Ischaemic Heart Disease (IHD).
  - Renal impairment GFR < 60
  - Current smokers

Lists of eligible participants created and distributed to GP

- Patients were identified by reviewing relevant pathology results from the previous year as well as clinical medical record searches
- Lifestyle factors that negatively impact patient health such as smoking were also considered.
- Smokers with diabetes are at increased risk of illness and premature death. This is especially true of older patients as well as those patients with existing co-morbidities.

GP reviewed list of potential participants

- The GP reviewed the list of referred patients to confirm eligibility and ability to participate.

Patients phoned by the nurse assigned to the project

- This was an important first step in establishing a relationship between the patient and nurse. At this stage the nurse;
  - Confirmed patient's preferred doctor
  - Enrolled patient in enhanced cycle of care
  - Booked the case conference

The nurse used a template to record answers in the patient's medical record that were referred to throughout the project. She made project appointments that were a different name and colour to standard appointments. This visual aid assisted in tracking patient participation and made it easy to follow up if patients did not attend.

Patient consent to participate in project obtained during consultation with GP

- It was important to have specific project appointments so that the appropriate time was given for the GP to discuss the project and make sure that the patient was fully informed of all steps of the project and given the information statement. Written patient consent was obtained during this consultation with their preferred GP. The signed consents were scanned into the medical record.

Commence enhanced cycle of care

- Patients attend case conference with their GP, nurse and team member
- Patients encouraged during case conference to identify personal health priorities
- Personal care plan formulated and implemented.

Commence regular nurse contact

- Each patient contacted by project nurse at scheduled intervals
- Barriers to progress or compliance with plan discussed and escalated to the GP
- Care provided dependant on individual care plan and needs.

Complete enhanced cycle of care

- Personal care plans to be reviewed annually or as they are due according previously established schedule
- Scope to review in the event of significant change.

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