Wimmera Health Care Group

Appointments through Community Health
25 David St Horsham PH: 5362 1243

diabetes self management

PROGRAM

Who is the program for:

- Newly diagnosed Type 2 Diabetes patients (within 12 months of diagnosis).

What does the program provide:

- Registered Div 1 nurse management.
- Teaching and empowering of good self management skills at early onset.
- Assessing coping skills and social supports.
- Screening for mental health issues (K10).
- $650 package per client to enable lifestyle changes and access to services eg. gym, smoking cessation, private dentistry, weight loss.
- Ongoing support of lifestyle changes.

This work complements General Practice cycle of care and team care arrangements through:

Workload prioritisation of GP's, Practice Nurses and DNE's:

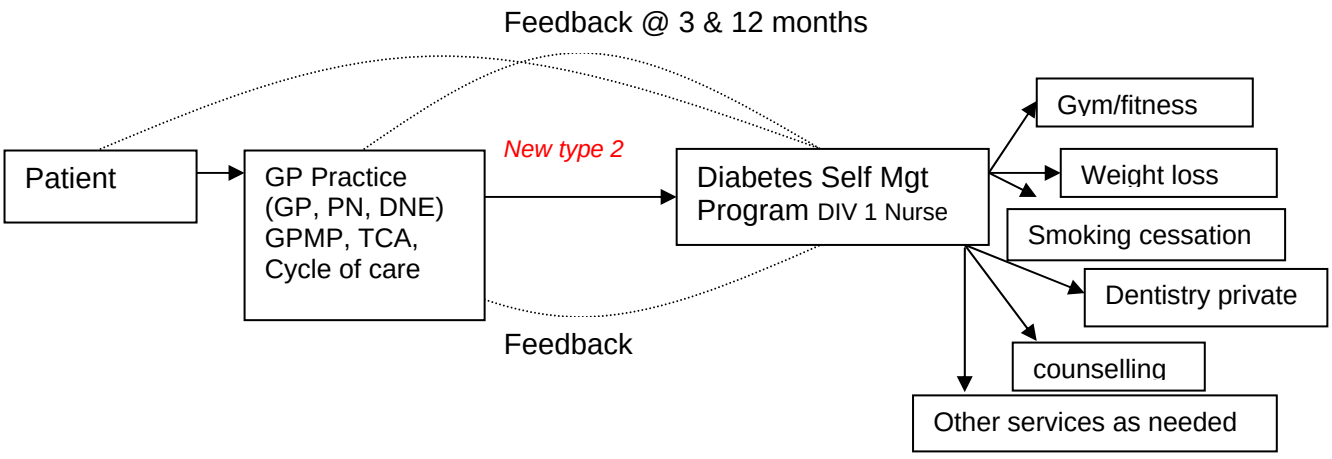
- Self management education is time consuming, GPs, PNs & DNEs time is valuable.
- In the Diabetes Self Management program the patient learns to **self** manage their diabetes therefore decreasing acute presentations and ultimately avoiding long term complications.
- Adding value to quality team care.
- Enables GP practice to focus on actual disease rather than psycho-social factors that impact on ability to self manage.

Business case – Diabetes self management program provides:

- Patient support for 14.5 hours over 12 months (not limited).
- Program has no cost to GP or patient.
- Does not affect PIP or Medicare payment.
- Minutes saved doing patient self manage education enables GP, PN and DNE to service other more complex clients as precious time not consumed by self management education.
- GP practices less crowded by Type 2 patients as these patients managing better.

Feedback loop

- letter provided to GP team (and copy to patient) with outline of patient's individualized progress within the program at 3 months and 12 months (see over for copy)



Diabetes Self Management
Community Health Nurse
Wimmera Health Care Group
Baillie St
Horsham VIC 3400
Ph: 03 5362 1243

Date

Dear Doctor _____,

Thank you for your referral dated the _____2008. Mr/Mrs/Ms _____ was seen on_____2008 in regards to Diabetes Self-Management. Below is a summary of information gained during further assessment using the Flinders Assessment and Goal Setting tools.

To compliment your current treatment and referrals, Mr/ Mrs/Ms_____has been referred to the following:

List of referrals goes HERE!

Please feel free to contact me if you should have any queries on 03 5362 1243.

Yours Sincerely

Tracey Pitts
Community Health Nurse
Diabetes Self Management Program