# Mayo Integrated Care Hub (CHN 1, CHN 2 and CHN 3)

| Service Name | Speciality | Service Descriptor | Service currently provided (Y/N) | Referral accepted by Health Link (Y/N) | Additional referral information required from GPs |
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| **Pulmonary Rehabilitation**<br><br>This is a comprehensive intervention based on a thorough patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and behaviour change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health enhancing behaviours | **Respiratory** | **Inclusion Criteria**<br><br>Confirmed diagnosis of COPD (via Spirometry) and on optimal medical treatment* as per the GOLD guidelines.<br>**OR**<br>Confirmed diagnosis of Asthma with the following:<br>• fixed airway obstruction<br>• deconditioning<br>• optimal medical treatment* as per the GINA guidelines<br>*Optimal medical treatment is considered 2-3 ICPCD/GP reviews post commencement of inhaler therapy.<br>• Functionally limited by dyspnoea despite optimal management (mMRC ≥ 2)<br>• Motivated to participate and change lifestyle<br>• Ability to exercise independently and safely (with or without a walking aid)<br>• If prescribed supplemental oxygen must have own portable supply and be independent in its use.<br>• Able to travel to venue | Y | Y | |
| **Physiotherapy 1:1 (Respiratory)**<br><br>This is a physiotherapist led clinic for patients diagnosed with COPD/Asthma. | **Respiratory** | **Inclusion Criteria**<br><br>COPD & Asthma patients > 16 years with issues regarding:<br>• airway clearance( sputum management)- ( upper and lower airways)<br>• breathlessness management<br>• cough management<br>• shortness of breath on exertion secondary to an underlying respiratory issue *(not cardiac or palliative)*<br>• individualised exercise assessment & prescription<br>• assessment and referral to pulmonary rehabilitation<br>• COPD education and self-management plans<br>• Within catchment area (Net 1,2 and 3) | Y | Y | |

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| **DESMOND**<br><br>Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) is a high quality structured patient education programme for people living with Type 2 diabetes.<br><br>**Education provided on**:<br>• Diabetes and Glucose<br>• Monitoring Type II<br>• Diet / Glucose Control<br>• Long term Effects<br>• Physical Activity<br>• Food and Health<br>• Self-Management Plan | **Diabetes** | **Inclusion Criteria:**<br>• ≥ 18 years of age<br>• Diabetes managed by lifestyle modifications only *or* with any type or combination of OHAs, SGLT2s, GLP1s and/or insulin<br>• Low, moderate, high risk/in-remission foot disease<br>• Up to and including stable CKD stage 3, if renal care is with GP (i.e. not under nephrologist)<br>• Recurrent hypoglycaemia or impaired awareness of hypoglycaemia<br><br>**Exclusion Criteria:**<br>• Paediatric or adolescent diabetes (< 18 years)<br>• Pre-diabetes<br>• Type 1 Diabetes<br>• Gestational Diabetes<br>• Women who are actively planning a pregnancy or who are pregnant<br>• Continuous subcutaneous insulin infusion therapy<br>• Maturity onset diabetes of the young<br>• Cystic fibrosis related diabetes<br>• Secondary<br>• Residential Care Home causes of diabetes e.g. Diabetes due to endocrinopathies, Pancreatitis, Post-pancreatic surgery, Post-transplant diabetes<br>• Genetic causes of diabetes e.g. Tumors, Klinefelters, Syndromes of insulin resistance etc. residents who cannot travel into clinic<br>• CKD Stage 4 & stage 5 and unstable Stage 3 (i.e. renal care is with nephrology services)<br>• Active Foot Disease (as per National Model of Care for the Diabetic Foot)<br>• Diabetic eye disease with active proliferative retinopathy/maculopathy or recent laser therapy or intra-vitreal injections (within the past 24 months)<br>• Autonomic neuropathy (with exception of erectile dysfunction)<br>• Active eating disorders<br>• Active Crohn's/ ulcerative colitis<br>• Pre- or post-bariatric surgery<br>• Receiving parenteral nutrition | Y | Y | 1. Medical History<br><br>2. Medication History<br><br>3. Recent blood results (HbA1c/Renal)<br><br>4. Non-invasive test results<br><br>5. Diabetic Foot screening must be completed in order for referral to be accepted |

## Mayo Integrated Care Hub (CHN 1, CHN 2 and CHN 3)

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| **Integrated Care Podiatry Service**<br><br>Providing standardised high-quality diabetes foot management for patients who are at **In-Remission Risk** of developing diabetic foot complications, as defined per Model of Care for Diabetic Foot 2021. | **Diabetes** | **Inclusion Criteria:**<br>• Previous foot ulcer<br>• Previous lower limb amputation<br>• Previous Charcot arthropathy<br><br>**Exclusion Criteria:**<br>• Patient < 18 years of age<br>• Active Foot ulceration/ Charcot foot disease/ Infection to be referred to Acute MdFT or A&E<br>• Low risk diabetic<br>• Nail and general foot care | Y | Y | 1. Medical History<br><br>2. Recent blood results (HbA1c/Renal)<br><br>3. Non-invasive test results<br><br>4. Diabetic Foot screening must be completed in order for referral to be accepted |