Healthlink Referral Guidelines for Cavan Monaghan Chronic Disease Management Service

Chronic Disease Hub CavMonaghan Covering CHN Cavan (CHN 7) and CHN Monaghan (CHN 8)		**Cavan**	**Monaghan**
	Phone	049 4373155	047 74661
	Email	chronicdiseasecavmon@hse.ie	
	Opening Hours	9am – 5pm Monday - Friday	
Version 8 Updated 17/04/2024			

Service Name and Descriptor	Speciality	Service criteria	Service currently provided (Y/N)	Referral accepted by Healthlink (Y/N)	Additional referral information required from GPs
Respiratory Integrated Consultant This is a Consultant led clinic where patients are offered 1:1 Consultant intervention, receiving individually tailored assessment/ medication review and prescription as required. Patients may be referred to other members of the Respiratory Team	**Respiratory**	**Inclusion Criteria** • > 16 years of age living in the Chronic Disease/CHN catchment area (Co Cavan or Co Monaghan resident) • Clinically confirmed Asthma or COPD with > 2 attendances in preceding 12 months at GP Practice (unscheduled) or attendance at GP out of hours or Emergency Department • Or High suspicion of COPD /Asthma with complex presentation • **Referrals will be declined if recent CXR and Spirometry are not included in referral**	Y	Y	1.Medical History 2.Recent blood results **3. Recent CXR results** **4. Results recent Spirometry.** 5. Smoking History 6. Occupational hazards with systematic exposure 7.Current use of Inhalers **Some appropriate referrals may be triaged by the Consultant to CNS Clinics**
PULMONARY REHABILITATION 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** Confirmed diagnosis of COPD (via Spirometry) and on optimal medical treatment* as per the GOLD guidelines. **OR** Confirmed diagnosis of Asthma for patients > 16 yrs living in CHN Catchment area with the following: • fixed airway obstruction • deconditioning • optimal medical treatment* as per the GINA guidelines *Optimal medical treatment is considered 2-3 ICPCD/GP reviews post commencement of inhaler therapy. • Functionally limited by dyspnoea despite optimal management (mMRC ≥ 2) • Motivated to participate and change lifestyle • Ability to exercise independently and safely (with or without a walking aid) • If prescribed supplemental oxygen must have own portable supply and be independent in its use. • Able to travel to venue	Y	Y	

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PHYSIOTHERAPY 1:1 (RESPIRATORY) This is a physiotherapist led clinic for patients diagnosed with COPD/Asthma.	**Respiratory**	**Inclusion Criteria** • COPD & Asthma patients > 16 years living in CHN catchment area with issues regarding: • airway clearance(sputum management)- (upper and lower airways) • breathlessness management • cough management • shortness of breath on exertion secondary to an underlying respiratory issue *(not cardiac or palliative)* • individualised exercise assessment & prescription • assessment and referral to pulmonary rehabilitation • COPD education and self-management plans	Y	Y	
RESPIRATORY CNS INTEGRATED CARE This is a Respiratory Clinical Nurse Specialist clinic for patients diagnosed with COPD/Asthma.	**Respiratory**	**Inclusion Criteria** • COPD & Asthma patients > 16 years living in CHN catchment area diagnosed by spirometry for; • Education – Medication, Diet, Exercise, Smoking Cessation • Self-Management • Inhaler education and review • Patients on treatment for , or diagnosed with Asthma or COPD with a poorly controlled disease as evidenced by access to healthcare in the previous 6 months via; GP Out of Hours Attendance Emergency Dept Attendance Hospital Admission **Exclusion Criteria** • Patients in acute exacerbated phase • Patients with acute or chronic respiratory symptoms who have not been fully investigated ie. Baseline PFTs/CXR	Y	Y	

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STOP SMOKING SERVICE The HSE Stop Smoking Service provides free, confidential support to anyone over 18 who wishes to quit tobacco or electronic cigarettes. If client is GMS, recommendation for NRT to be sent to GP for client to receive on GMS system. If client is non GMS, recommendation is sent to chosen Pharmacy where client can access up to 12 weeks free combination NRT.	All Specialties	**Inclusion Criteria** > 16 years of age living in the Chronic Disease/CHN catchment area (Co Cavan or Co Monaghan resident) This support can be provided face to face, on the phone or virtually on a weekly/fortnightly basis initially and continues for up to 1 year from the clients quit date. Our service focuses on the addiction, habit and emotional attachment that clients develop to nicotine. Behavioural support is provided along with client-centred combination NRT recommendations in line with Clinical Guidelines and Quality Assurance Guidelines developed in 2022. This increases chances of quitting successfully x 4 fold.	Y	Y	All referrals to the service should include the following: • Name • Address • Telephone Number • Consent to be referred and interested in quitting • Any Chronic Diseases – COPD/Asthma, Type 2 Diabetes, Cardiovascular Disease (including heart failure, heart attack (angina), stroke, irregular heartbeat (atrial fibrillation) and relevant MH history
Spirometry +/- reversibility Testing Spirometry is a physiological test that assesses lung function by measuring the volume of air that the patient can expel from the lungs after a maximal inspiration. It will enable the general practitioner to: • Differentiate between COPD and asthma • Exclude COPD or asthma as a diagnosis. • Determine the efficacy of asthma treatment	**Respiratory**	**Inclusion Criteria:** • > 16 years age living in CHN catchment area • Patients with new onset symptoms suggestive of COPD/ Asthma Or • To confirm previous clinical diagnosis where spirometry not previously performed / to clarify uncertain previous spirometry based diagnosis Exclusion: • Paediatric or adolescent patients (< 16 years) • Patients with current diagnosis of respiratory condition • Service is for assessment of COPD and Asthma – all other respiratory conditions requiring investigation should continue to be referred through established pathways. • Patients who have any of the following contraindications: <u>Absolute Contraindications</u>	Y	Y	• Patient details • Reason for referral Current inhalers

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• Correctly stage and provide an index of severity of patients with COPD. Monitor disease progression		○ Patient should not be tested within 1 month of a Myocardial Infarction (MI) ○ AAA (>6cm) ○ Recent Pulmonary Embolism ○ Severe hypertension (SBP > 200mmHg, DBP >120mmHg) <u>Relative Contraindications</u> ○ Haemoptysis ○ Recent eye surgery ○ Recent Pneumothorax ○ Recent Abdominal/Thoracic Surgery ○ Confusion/ Dementia ○ Vomiting/Nausea ○ Contagious disease e.g. TB or Hep B etc.			

Service Name and Descriptor	Speciality	Service criteria	Service currently provided (Y/N)	Referral accepted by Healthlink (Y/N)	Additional referral information required from GPs
DIABETES INTEGRATED CONSULTANT This is a Consultant led clinic where patients are offered 1:1 Consultant intervention, receiving individually tailored assessment/ medication review and prescription as required. Interventions are supported by collaborative goal setting and management techniques.	**Diabetes**	**<u>Inclusion Criteria</u>** • ≥ 16 years of age living in CHN catchment area • Newly Diagnosed Type 2 Diabetes with complex presentation (uncomplicated diagnosis to be managed by GP) • Suboptimal Glycaemic Control – HbA1c >58mmol/mol on 2 or more agents (Oral or Injectable) • Problematic hypoglycaemia eg.recurrent or unaware • Adult patients with Type 1 Diabetes who default from	Y	Y	1.Recent blood results (HbA1c/Renal) 2.Retinal Screen Results 3.Non-invasive test results **Some appropriate referrals may be triaged by the Consultant to CNS Clinics**

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		secondary care with a view to re engaging with secondary Care.			
GP E MAIL ADVISORY SERVICE	**Diabetes**	**Inclusion Criteria** Clinical Questions related to T2DM care (including cardiovascular risk modification) of adult patients attending the GP **Exclusion Criteria** Urgent Clinical queries relating to acutely unwell patients Clinical queries unrelated to T2DM Patients under 16yrs Queries regarding patients who have been referred to the service Clinical Queries re Diabetes in Pregnancy	Y	Y	1.Medical History 2.Recent blood results (HbA1c/Renal) 3.Non-invasive test results
DISCOVER DIABETES -TYPE 2 Discover Diabetes- Type 2 is a high quality structured patient education programme for people living with Type 2 diabetes. Available in *face to face group session or virtually (webex). *Must be able to attend 4 x 2.5 hour sessions, then one session at 6 months and one session at 12 months, with 12-15 participants in face to face group and able to mobilise to enter the venue **Education provided on**: • Monitoring Type 2 Diabetes	**Diabetes**	**Inclusion Criteria:** • ≥ 16 years of age living in CHN catchment area • Confirmed diagnosis of Type 2 Diabetes • Diabetes managed by lifestyle modifications only *or* with any type or combination of OHAs, SGLT2s, GLP1s and/or **insulin **Exclusion Criteria:** • Paediatric or adolescent diabetes (< 16 years) • Pre-diabetes (refer to DPP) • Type 1 Diabetes • Gestational Diabetes / Type 2 DM and pregnant	Y	Y	Self referral on HSE live or via hub

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Service Name and Descriptor	Speciality	Service criteria	Service currently provided (Y/N)	Referral accepted by Healthlink (Y/N)	Additional referral information required from GPs
• Healthy Eating • Complications • Physical Activity • Self-Management and making change • Weight Management		• **Continuous subcutaneous insulin • infusion therapy • Cystic fibrosis related diabetes • CKD Stage 4 & stage 5 and unstable Stage 3 (i.e. renal care is with • nephrology services) • Post bariatric surgery (must be 2 years post surgery) • Parenteral Nutrition or enteral tube feeding • Eating disorders • Diagnosis complex physical or intellectual disabilities • Complex mental health needs			
DIABETES PREVENTION PROGRAMME A high quality structured patient education *virtual programme for people diagnosed with pre-diabetes or at risk of developing Type 2 Diabetes (over a 12 month period with up to 12-15 attendees). *face to face group is not available at present, and is being piloted nationally at present **Education provided on**: • Healthy Eating • Physical Activity	**Diabetes**	**Inclusion Criteria:** < 16 years of age living in the Chronic Disease/CHN catchment area (Co Cavan or Co Monaghan resident) • HbA1c 42-47 mmol/mol in last 3 months • women with a history of gestational diabetes with a HbA1c 42-47 mmol/mol in last 3 months **Exclusion Criteria:** • Paediatric or adolescent diabetes (< 16 years) • Type 1 Diabetes • Type 2 Diabetes • CKD Stage 4 & stage 5 and unstable Stage 3 (i.e. renal care is with	Y	Y	Self referral on HSE live or via hub

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• Self-Management and making change • Weight Management		• nephrology services) • Post bariatric surgery (must be 2 years post surgery) • Parenteral Nutrition or enteral tube feeding • Eating disorders • Diagnosis complex physical or intellectual disabilities • Complex mental health needs • Pregnancy • Active eating disorder			
DIABETES PODIATRY SERVICE 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:** > 16 years of age living in the Chronic Disease/CHN catchment area (Co Cavan or Co Monaghan resident) • Previous foot ulcer • Previous lower limb amputation • Previous Charcot arthropathy **Exclusion Criteria:** Active Foot ulceration/ Charcot foot disease/ Infection to be referred to Acute Podiatry/ MDFT Multidisciplinary Foot Team or A&E • Low risk diabetic • Nail and general foot care	Y	Y	1.Medical History 2.Recent blood results (HbA1c/Renal) 3.Non-invasive test results 4.Diabetic Foot screening must be completed in order for referral to be accepted
Dietitian 1:1 clinic (Type 2 Diabetes) This is a dietitian led clinic where patients can be offered 1:1 dietetic interventions, receiving individually tailored assessment and interventions supported by collaborative goal setting and management techniques.	**Diabetes**	**Inclusion Criteria:** • ≥ 16 years of age living in CHN catchment area • Confirmed diagnosis of Type 2 Diabetes with a HbA1C > 58mmol/mol who require any type or combination of OHAs, SGLT2s, GLP1s and/or *insulin • Patients with Type 2 Diabetes with poor glycaemic control, recurrent hypoglycaemia, or steroid induced hyperglycaemia • Confirmed diagnosis of Pre Diabetes if not suitable for DPP	Y	Y	1. Medical & surgical History 2. Medication History 3.Recent blood results (HbA1c,Renal profile, Calcium. Vit D, Vit B12, lipid profile) 4.Non-invasive test results 5. Previous weights

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Education provided on: • Diet • Weight management • Alcohol • Smoking • Physical activity • Medication • Lifestyle factors		**Exclusion Criteria:** • Paediatric or adolescent diabetes (< 16 years) • Type 1 Diabetes • Gestational Diabetes / Type 2 DM and pregnant • *Continuous subcutaneous insulin • infusion therapy • Cystic fibrosis related diabetes • CKD Stage 4 & stage 5 and unstable Stage 3 (i.e. renal care is with • nephrology services) • Post bariatric surgery (must be 2 years post surgery) • Parenteral Nutrition or enteral tube feeding • Eating disorders • Diagnosis complex physical or intellectual disabilities • Complex mental health needs • Residential Care Home residents who cannot travel into clinic • Diabetes due to endocrinopathies, Pancreatitis, Post- pancreatic surgery, Post-transplant diabetes			6. relevant social history
Diabetes CNS Integrated Care This is a Diabetes Clinical Nurse Specialist clinic for patients diagnosed with Diabetes with the inclusion criteria as stated.	**Diabetes**	**Inclusion Criteria:** Non Pregnant Adult over 16 years of age living in CHN catchment area Patients with HBA1C >58 despite two or more oral agents Patients who require GLP1 initiation Patients who require insulin initiation Patients with poor glyaemic control on insultin therapy Steroid induced hyperglycaemia Recurrent hypoglycaemia Hypoglycaemia unawareness	Y	Y	1.Patient Details 2. Reason for referral including HBA1C 3. Past Medical and Surgical History 4. Full list of current medications 5. Previous diabetes medications that were discontinued

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		Patients who default from secondary care including adult patients with Type 1 diabetes with a view to re-engaging them with services in secondary care.			and reason for discontinuation 6. Diabetes Complications as per recent CDM review 7. Pre Referral work up to accompany referral FBC, Fasting Lipids, U&E, Cretinine, HBA1C, LFT's Microalbuminuria and eGFR. 8. Most recent retinal screen report

Service name and descriptor	Speciality	Service Criteria	Service currently provided (Y/N)		Additional referral information required from GPs
Consultant Cardiologist	**Cardiology**	**Cardiology Clinic** • Non urgent Cardiac presentation requiring consultant review • Clinical examination, PMH and family history (with ages). • Bloods: FBC, Lipid Profile (including LDL), Mg, Renal, Liver, Thyroid, NT-pro BNP, TSAT and Ferritin HbA1c (not if he/she had the last 2 months) • ECG: 12 Lead recent ECG • **Referrals will be declined if this information is not included**	**Y**		**Some appropriate referrals may be triaged by the Consultant to CNS Clinics** Over 16 yrs living in Cavan or Monaghan CHN catchment area Willing and able to attend clinics
CNS Cardiology Integrated Care	**Cardiology**	**CNS Led Palpitation Clinic** (this is not an urgent access clinic – if you have concerns please refer to AMAU/ED locally) **Referrals must include** Past Medical History (Family HX with ages of CVD)	Y		Please perform 24 hr BP Monitor before referring the patient to have accurate BP readings so risk

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		Recent Bloods include FBC, TFTs, Iron/Ferritin Levels **Inclusion Criteria;** • Has an Email address • Uses a smart phone for downloading the KardiaMobile App • Palpations last longer than 1 Minute **Exclusion Criteria** • Unable to use KaridaMobile App • Family History of sudden cardiac Death • History of Collapse/loss of consciousness • Abnormal resting ECG **<u>CNS Led Hypertension Clinic</u>** **Referrals must Include** 1.Past Medical HX – Family HX CVD and Ages 2.New ECG 3.Clinical Examination (any significant murmer) 4.New blood exams (FBC, TFT, Renal, Liver, Full Lipid Profile including LDL, HbA1c,Na,Ca,Trop,NT-pro BNP, Urinary Albumin Creatinine Ratio and Aldosterone to renin ratio) 5. List of current medication **Inclusion Criteria** • Office BP> 140mmHg Systolic reading on more than one reading or • An ABPM > 130mmHg systolic reading **Exclusion Criteria** • BP > 180mmHg systolic or 110mmHg diastolic – urgent ax in AMAU needed • Orthostatic HTN • Pregnancy • Renal Transplant **<u>CNS Led Lipid Clinic</u>** **Referrals must include;** 1.Past Medical HX – Family HX CVD and Ages 2.New ECG 3.Clinical Examination (any significant murmer) 4.New blood exams (FBC, TFT, Renal, Liver, **Full Lipid Profile including LDL& Tryglycerides**, HbA1c,Na,Ca,Trop,NT-pro BNP, Urinary Albumin Creatinine Ratio and Aldosterone to renin ratio) 5. List of current medication **Inclusion Criteria**			stratification can be completed – if this cannot be done please ask the patient to complete 7-10 days home BP readings 2-3 values per day. **Office BP readings are not ideal for final diagnosis**

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		• Raised Lipid Profile • Raised LDL for cardiovascular risk stratification • Family HX of CAD with hyperlipidaemia **Exclusion Criteria** • <16yrs • Pregnant			

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Cardiac Rehabilitation 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 cardio vascular disease and to promote the long-term adherence to health enhancing behaviours	Cardiovascular	Inclusion Criteria Myocardial Infarction Cardiac Transplant Percutaneous Coronary Intervention Diagnosis of heart failure NYHA I –II Coronary artery bypass surgery Independently mobile Coronary valve surgery Pacemaker TIA Mild Stroke with NIHSS < 5 or MRS <3 Exclusion Criteria Critical aortic stenosis (peak pressure gradien >50mmhg with aortic valve orifice <0.75cm2 in average size adult). Uncontrolled hypertension: resting systolic blood pressure >200mmhg or resting diastolic >110mmhg Metabolic problems e.g. acute thyroiditis, hypo/hyperkalaemia, hypovolaemia. Mental or physical impairment leading to inability to exercise safely. Unstable/exercise induced angina or ischaemic changes on resting ECG. Severe orthopaedic problems that would prohibit exercise. Third Degree (complete) heart block without a pacemaker. Orthostatic blood pressure drop >10mmhg with symptoms. Acute/recent pulmonary emboli or infarction. Acute/recent pulmonary emboli or infarction. Acute myocarditis or pericarditis Uncontrolled atrial or ventricular arrhythmias. Acute aortic dissection Exercise induced arrhythmias. Hypertrophic obstructive cardiomyopathy Uncontrolled diabetes Acute systemic illness or fever. Decompensated heart failure NYHA III and IV Uncontrolled sinus tachycardia (>120BPM). Thrombophlebitis Bypass surgery New onset atrial fibrillation	Y	Y	**Recent results of;** **Angiogram** **Echocardiogram** **Carotid Doppler** **Cardiac Monitoring** **Bloods** **CT brain** **MRI Brain**