

Central West Gippsland
Management of Type 2 Diabetes Flow Chart (DRAFT version 3)

Diagnosed with Type 2 Diabetes

Preparation of General Practitioner Management Plan (GPMP) MBS#721
 GP assesses all health concerns, needs and goal. With patient develops a diabetes management plan and commences a Diabetes 12 month cycle of care.

Standard Consultation MBS#23 or MBS #36
 GP assesses all health concerns and with the patient develops a pathway of care.

Create Team Care Arrangements (TCA) MBS#723
 Patients with Type 2 diabetes, who have a GPMP and multiple complex needs, qualify for a Team Care Arrangement. Identify and confirm with the patient which other service providers and treatments are required. Contact proposed service providers and obtain agreement to participate in the care of the patient. Communication must be two-way, preferably verbal but may be in writing (including telephone, fax, email or mail, ensuring privacy is safeguarded).

Diabetes care via a GPMP/TCA Care Pathway

Diabetes Care via normal GP referral pathway

Enhanced Primary Care (EPC) Items
 If appropriate refer patient to allied health providers for up to 5 MBS services per year.
 GP must use the mandated Commonwealth EPC referral form.

Private consultation at cost to patient
 (i.e. patient with private health insurance)

Latrobe Community Health Service
 Refer patient to Latrobe Community Health Service Intake Worker

- Stay Healthy Latrobe Program (patients with no complications who are newly diagnosed with Type 2 diabetes)
- Group Education Program
- Individual consultations with appropriate allied health professional/s

Phone: 1800 242 696
Fax: 5133 1672

West Gippsland Healthcare Group
 Refer patient to West Gippsland Healthcare Group

- Group Education Program
- Individual consultations with appropriate allied health professional/s
- Diabetes Self Management Program (for people who are newly diagnosed with Type 2 diabetes)

Phone: 5624 3500
Fax: 5624 3555

Private Health Providers

Public Health Providers

Stay Healthy Latrobe (Latrobe City)

Stay Healthy Latrobe is a program designed to assist people, who have been newly diagnosed with Type 2 Diabetes, to manage their condition. The program adopts a team approach consisting of a Key Worker, Health Care Professionals and GPs.

The Key Worker assesses individual health and lifestyle. They help clients plan how to manage their condition, by encouraging lifestyle changes, discussing obstacles and planning future goals.

The Stay healthy Latrobe Program motivates and supports people with Type 2 Diabetes, which results in fewer complications and a better quality of life.

Diabetes Self Management Program (Baw Baw Shire)

The Diabetes Self-Management program provides people newly diagnosed with type 2 diabetes with early intervention packages. The self management packages provide support to people to become good self-managers of their health, so as to maintain good health and to prevent future complications.

Medicare Explanatory Notes