ADS Guide For The Management Of Diabetes During the COVID-19 pandemic

The COVID-19 pandemic has changed the focus of clinical services. This impacts diabetes care at tertiary, secondary and primary care levels. Indeed, we have a responsibility to ensure that critical diabetes care continues, with the aims being to minimise the burden on the hospital system as well as to ensure that long-term glycaemic control for people with diabetes continues and complications are prevented. While the elective and non-urgent components of diabetes care need to be modified, postponing their delivery is counter-productive in the long run particularly given the uncertainty regarding the duration of the COVID-19 situation. Health care systems should therefore innovate and provide service delivery while adhering to the social distancing precautions and redeployment of staff in many hospital-based services.

All tertiary level services have modified or closed diabetes out-patient clinics to minimise face-to-face consultations. This has required a change in the service delivery models and a move towards telephone/telehealth services. However, there are a number of diabetes-specific activities that require face-to-face interaction with a diabetes health professional. Below we outline services that need to be considered for face-to-face consultation and services that could be provided safely remotely. Additional considerations for service delivery design will be the local COVID-19 status and local decision-making processes.

Diabetes Services to consider:

Emergency admissions and inpatient care services: These relate to emergency department presentations that require admission and medical management, including:

- severe hypoglycaemia, diabetic ketoacidosis (DKA), hyperosmolar hyperglycaemic state (HHS)
- other acute diabetes related complications requiring hospitalisation for optimal care, such as severe/systemic foot infections, gas gangrene or acute limb-threatening ischaemia. These require immediate treatment to avoid complications and to facilitate quick discharge to minimise length of stay and risk of infection.

Outpatient clinical services: These include outpatient clinic attendances to access services of diabetes specialists, diabetes nurses, dietitians, psychologists, podiatrists. These need to be assessed in the light of local decision-making processes and should be focussed on those required to avoid hospital emergency department attendances where possible.

Telephone/telehealth delivered diabetes services: These include routine diabetes care services that can be delivered in a remote manner using telephone/telehealth services such as device upload reviews and routine diabetes care especially for those with type 1 diabetes or other complex diabetes settings.

Emergency admissions and inpatient care

When considering diabetes related emergency department and hospital admissions the following should be considered:

- Organisation of teams to include a core team on a rotating roster for a period of time. Designate a lead consultant who is relieved from other clinical duties to co-ordinate diabetes patient care from the time of presentation to the emergency department through to specialist care and discharge.
- The evidence suggests that people with diabetes are more likely to have more severe complications with COVID-19. Inpatient diabetes services will therefore need to continue (and potentially increase their capacity) to:
    - support care of in-patients with diabetes and COVID-19
    - support other in-patients with diabetes to minimise length of stay
    - provide remote support as required for people who have been discharged to avoid readmission.
- Protection of healthcare workers who provide direct patient care or who are physically present at workplaces. Ensure rational use of protective personal equipment (PPE), adhering to local protocols. These need to be prefaced to be of highest priority for all patient encounters and any advice given should be in line with the Government recommendations.
- Backup plans need to be in place for management of service delivery when health care team members are quarantined or unwell.

Outpatient clinical services

Where possible outpatient services should continue to be delivered through utilisation of telephone or telehealth options. Clinic lists should be reviewed in advance to pick out high-risk patients who may still require face-to-face visits.

Services that will generally need to be provided face-to-face using outpatient services include:

- Inter-disciplinary diabetes foot services
- Pregnancy and diabetes services – although many contacts regarding diabetes management can be performed remotely
- Insulin starts
- The combination of requiring insulin treatment, having increased risk of hypoglycaemia and lack of ability or facility to download meters or other diabetes technology (insulin pumps, continuous glucose monitoring, flash glucose monitoring) for remote review

When required there should be provisions to conduct face-to-face clinics in an environment which is considered safe and appropriate - in a clinic or private rooms where provision has been made to limit risk of exposure to COVID-19 infection, or where necessary for performing a procedure (including diabetes technology device uploads).

Telephone/telehealth delivered diabetes services

These include routine diabetes care consultations that can be delivered remotely taking into account long-term chronic disease management and prioritisation, as well as individual risk factors and clinical needs.

- Administrative support is still required to ensure timely delivery of prescriptions, investigation requests, endorsement of drivers' licences and NDSS forms to patients and to book review appointments.
- Minimise investigations to the essentials required for clinical decision making, to avoid patient travel to blood collection centres and to enhance social isolation while also easing the load on the pathology collection and laboratory services
- The present bulk billing incentives for remote consultations have been expanded with the specific intention of:
    - limiting patient risk of exposure to COVID-19 through them compromising self-isolation
    - limiting practitioner need to use PPE for patient encounter

Australian Diabetes Society

General considerations

- Diabetes services should try to maintain and improve the health of people with diabetes during the COVID-19 pandemic.
- Services with serious implications, for example risk of amputation due to an active diabetes foot ulcer, should not be deferred/cancelled if possible.
- Some non-urgent patient contacts could be postponed, but there may not be sufficient capacity in the future to 'catch-up', so it should be acknowledged that postponement will equate to cancellation in a proportion of cases.
- Group educational activities will need to be reconsidered to reduce risk of infection. Use of web-based social platforms may be more appropriate.
- Liaising with locally available services to enhance remote care such as tele-interpreter service, disability services, community transport and community mental health services. Where these are in question face-to-face contact is likely to be needed.
- Where possible consultation should be performed remotely, e.g. telephone, email, telehealth, acknowledging that some personal contact may be required to provide blood for pathology testing.
- A visit for blood testing should be organised if it is required to inform diabetes management. This should be performed in a manner that will minimise the exposure of the person with diabetes.

The COVID-19 pandemic has changed the way that health care delivery is provided and we must quickly adapt to provide effective diabetes care that does not expose the person with diabetes or the health care professional to infection. These suggestions do not comprehensively cover all diabetes services that any particular provider may be delivering, but do provide a framework for considerations and prioritisations.